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THE JOURNAL
— OF THE —
Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XXIII
NO 1

Jacksonville, Florida, July, 1936

Yearly Subscription, $3.00
Single Copy, 30c

1936-37

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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924.

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Lanier, W. T.,
336 Ingraham Bldg. Miami
Laymon, R. L.,
300 Venetian Arcade Bldg....Miami
Leavitt, H. A.,
127 N. E. 5th St. Miami
Lefholz, Rotbwell,
1009 Huntington Bldg.....Miami
Levin, Alfred G.,
Jackson Memorial Hospital, Miami
Lewis, Taylor,
302 Congress Bldg.....Miami
Light, S. D. W.,
Ingraham Bldg.....Miami
Lithgow, William D.,
2200 Biscayne Blvd Miami
Litterer, A. B.,
309 Huntington Bldg.....Miami
Lott, Young C.,
144 N. E. 2nd Ave.....Miami
Lovejoy, M. A.,
417-20 Sweet Bldg...Ft. Lauderdale
Lowe, Eugene C.,
268 N. E. 21st St.....Miami
Lucinian, Joseph H.,
403 Huntington Bldg.....Miami
Lustgarten, A.,
1527 Washington Ave., Miami Beach
Lyell, R. O.,
310 Huntington Bldg.....Miami
McClamroch, James M.,
410 Ingraham Bldg. Miami
McDonald, John T.,
312 Huntington Bldg.....Miami
MacDonell, Geo. N.,
P. O. Box 1861.....Miami
McGunagle, J. E.,
1886 W. Flagler St.....Miami
McKenzie, E. N.,
336 Ingraham Bldg.....Miami
McKenzie, Jack A.,
Huntington Bldg. Miami
McKibben, Wm. W.,
316-18 Ingraham Bldg.....Miami
McShane, James K.,
307 Ingraham Bldg.....Miami
Manson, Plumer J.,
277 N.E. 82nd St. Miami
Marsh, Lucille J.,
812 Huntington Bldg. Miami
Martin, M. C.,
1774 S.W. 8th St. Miami
Maxwell, Eugene B.,
337 Lincoln Road.....Miami Beach
Medlin, Willard B.,
502 Security Bldg.....Miami
Mentzger, Claude,
2701 Biscayne Blvd. Miami
Milton, J. D.,
603 Huntington Bldg. Miami
Moore, T. Earl,
Menninger Sanatorium,
Topeka, Kans.
Morrow, Frank R.,
1006 Huntington Bldg. Miami
Mosley, R. Sam,
Seybold Bldg. Miami
Nichol, E. Sterling,
305 Huntington Bldg.....Miami
Nugent, J. J.,
10 E. Rio Alta Island, Miami Beach
O'Quinn, Leon H. Hialeah
Otto, T. O.,
704 Huntington Bldg.....Miami
Owens, Duncan,
337 Lincoln Road.....Miami Beach
Palmer, Bascom H.,
502 Huntington Bldg.....Miami
Panettiere, Cayetano,
P. O. Box 227.....Miami Beach
Paulk, George A.,
202 Venetian Bldg.....Miami
Payton, Frazier J.,
Allison Hospital Miami Beach
Pearson, Colquitt,
1107 Huntington Bldg.....Miami
Pearson, Homer L., Jr.,
1108 Huntington Bldg.....Miami
Pearson, John R.,
602 Olympia Bldg.....Miami
Pearson, Nelson T.,
1109 Huntington Bldg.....Miami
Pearson, Rufus J.,
Huntington Bldg.....Miami
Pepper, Max,
719 Seybold Bldg.....Miami
Perdue, Jean,
1213 Lincoln Road....Miami Beach
Perdue, John R.,
Ingraham Bldg. Miami
Perry, C. Larimore,
609 Huntington Bldg.....Miami
Peters, Edgar,
506 Olympia Bldg.....Miami
Phillips, Kenneth,
610 Huntington Bldg.....Miami
Pollock, Benjamin,
952 Collins Ave. Miami Beach
Preston, E.,
St. Francis Hospital..Miami Beach
Putnam, J. H.,
305 Huntington Bldg.....Miami
Quillian, Warren,
Coral Gables Clinic....Coral Gables
Raap, Gerard,
908 Huntington Bldg.....Miami
Reiss, George L.,
Lincoln Road Miami Beach
Rentz, L. S.....Coconut Grove, Miami
Rentz, William C.,
3532 N. W. 17th Ave.....Miami
Repass, Robt. E.,
835 Lincoln Road Miami Beach
Richardson, James C.,
509 Olympia Bldg. Miami
Richardson, John R.,
Lincoln Road.....Miami Beacb
Rinaman, James,
6043 N. E. 2nd Ave.....Miami
Roberts, Sam J.,
347-8 Ingraham Bldg. Miami
Roche, Chas. F.,
P. O. Box 483.....Miami Beach
Rogers, Hunter B.,
27 N. W. 12th Ave.....Miami
Roth, Edward,
904 Collins Ave. Miami Beach
Ryan, Harold A.,
Aladdin Medical Arts Bldg.,
Miami Beach
Salley, S. Marion,
440 Ingraham Bldg. Miami
Sams, Wiley M.,
312 Ingraham Bldg.....Miami
Sayles, Chas. F.,
311 N. W. Third St.....Miami
Scarbrough, C. A.,
800 N.E. 2nd Ave. Miami
Schaeffer, O. N.,
931 Catalonia Ave Coral Gables
Seeds, John B.,
544 W. Flagler St.....Miami
Shaw, E. Clay,
702 Huntington Bldg.....Miami
Shisler, J. W.,
409 Olympia Bldg. Miami
Silverman, Harry Z.,
760 Collins Ave.....Miami Beach
Skaggs, P. T.,
510 First Natl. Bk. Bldg.....Miami
Skilling, Francis C.,
401 Ingraham Bldg.....Miami
Smith, C. Kirby,
300 Ingraham Bldg. Miami
Smith, J. A. Homestead
Smith, J. W.,
1661 W. Flagler St. Miami
Smith, Marvin,
405 Huntington Bldg.....Miami
Snyder, John W.,
402 Huntington Bldg.....Miami
Spicer, Robert T.,
1409 Huntington Bldg.....Miami
Stewart, Franz,
1105 Huntington Bldg.....Miami
Stewart, J. S.,
1105 Huntington Bldg.....Miami
Stuart, J. D.,
227 N. E. 5th St.....Miami
Tallman, Maurice H.,
1401 Huntington Bldg.....Miami
Thomas, Edwin C.,
46 N. E. 5th St. Miami
Thomas, Kelly C.,
318 N. W. 1st St.....Miami
Thomas, Merrick D.,
756 N.W. 36th St. Miami
Thomson, Wm. Ross,
835 Lincoln Road.....Miami Beach
Thorne, James I.,
300 Seybold Bldg. Miami
Tower, John B.,
32 N. Krome Ave.....Homestead
Travers, Milton P.,
Ingraham Bldg. Miami
Tumlin, C. E.,
Tumlin Bldg., 800 N.E. 2nd Ave.,
Miami
Turner, John C.,
300 Ingraham Bldg. Miami
Vinson, Willie J.,
400 Ingraham Bldg.....Miami
Vogt, Ferdinand A.,
802 Huntington Bldg. Miami
Voris, Frank B.,
541 Lincoln Road Miami Beach
Walters, Arthur L.,
Lincoln Road Miami Beach
Watters, Wm. H.,
Boston-Miami Clinic,
Coconut Grove, Miami
Weiland, Arthur H.,
227 Aragon Ave.....Coral Gables
Weinkle, Barney,
302 Huntington Bldg.....Miami
Welch, P. B.,
Huntington Bldg.....Miami
Welchel, Lynn W.,
Ingraham Bldg. Miami
White, D. Ward,
1659 Washington Ave., Miami Beach
Whitten, Benj. L.,
414 1st National Bk. Bldg., Miami

* Deceased. † Honorary Member. § Life Member.

Wilson, M. C.,
809 Huntington Bldg.....Miami
Withers, G. H.,
Aladdin Med. Arts Bldg.,
Miami Beach
Wood, Arthur W.,
401 Security Bldg.....Miami
Woodard, Robert C.,
Jackson Memorial Hospital..Miami
Wright, Scheffel,
315 Ingraham Bldg.....Miami
Yarbrough, Henry C.,
127 N.E. 5th St. Miami
Youmans, Corren P.,
Veterans Hospital...St. Petersburg
Youmans, I. C.,
653 S. E. 2nd St.....Miami

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY (DISTRICT "D")

McKnight, George S., President,
Jacaranda Arcade Avon Park
Martin, Leldon W.,
Sec'y-Treasurer Sebring
Aurin, E. C. Ft. Ogden
Bevis, Henry P.....Arcadia
Boorom, Hartley E.,
37-39 S. Ridgewood Dr.....Sebring
Brewster, Guy O. Avon Park
Chandler, Isaac W.,
First Trust Bldg.....Avon Park
Eide, A. T. Lake Placid
Highsmith, G. F. Arcadia
Kayton, M. C. Wauchula
Kirkpatrick, Charles H.,
Box 454 Arcadia
McDaniel, Thomas F.....Sanford
McSwain, Gordon Henry.....Arcadia
Peacock, W. H. Wauchula
Poucher, A. A. Wauchula
Simmons, John A.....Arcadia
Simmons, S. J., Jr.....Belle Glade
Spears, Ben D. Wauchula
Touchton, W. C.....Avon Park
Weems, Howard V.,
22 Oak St. Sebring

DUVAL COUNTY MEDICAL SOCIETY (DISTRICT "C")

Shaw, W. McL., President,
St. James Bldg. Jacksonville
Morris, Kenneth A., President-elect,
237 W. Duval St.....Jacksonville
Mabry, Charles B., Vice-President,
439 St. James Bldg. ...Jacksonville
Porter, H. W., Secretary,
340 St. James Bldg....Jacksonville
Hayes, John W., Treasurer,
209 Professional Bldg., Jacksonville
Adams, George E.,
2017 Main St.....Jacksonville
Adams, Thomas S.,
612 Lynch Bldg. Jacksonville
Alford, Neil,
St. James Bldg.....Jacksonville
Arms, B. L.,
P. O. Box 353....Farmington, Me.
Baker, Robert M.,
Professional Bldg.....Jacksonville
Baumgartner, Carl J.,
406 Masonic Bldg.....Jacksonville
Bayless, W. C.,
202 St. James Bldg....Jacksonville
Beckman, George E.,
Professional Bldg.....Jacksonville
Black, J. B.,
St. James Bldg.....Jacksonville
Blackmar, Ray W.,
320 St. James Bldg....Jacksonville
Boone, James L.,
500 Professional Bldg, Jacksonville
Borland, J. L.,
University Club, 16th and
Locust Sts. Philadelphia, Pa.
Boyd, Charles W.,
111 W. Adams St. Jacksonville
Bransford, L. E.,
Professional Bldg.....Jacksonville
Brillhart, H. L.,
Graham Bldg. Jacksonville
Brink, Fritz A.,
Dist. Health Comm., Blackshear, Ga.
Brinson, P. A.....Baldwin
Brinson, W. D.....Baldwin
Broadbent, Oliver P.,
454 St. James Bldg.....Jacksonville
Brown, Alan DeWitt,
417 St. James Bldg....Jacksonville
Bryant, James M.,
303 Medical Arts Bldg., Jacksonville
Buckman, Thomas E.,
1022 Park St.....Jacksonville
Carefoot, E. I.,
Professional Bldg.....Jacksonville
Cason, Turner Z.,
2033 Riverside Ave.....Jacksonville
Chapman, Benjamin A.,
2151 Pearl St.....Jacksonville
Chilli, Joseph L.,
401 St. James Bldg. ...Jacksonville
Collins, C. C.,
1855 Laura St. Jacksonville
Copeland, Silas M.,
203 St. James Bldg.....Jacksonville
Copp, F. A.,
458 St. James Bldg....Jacksonville
Counts, H. W.,
312 Peninsular Life Bldg,
Jacksonville
Croft, George W.,
713 Greenleaf Bldg....Jacksonville
Croft, Theo. G.,
713 Greenleaf Bldg. ...Jacksonville
Cunningham, Lester W.....Mandarin
Day, Gaston,
310 W. Church St.....Jacksonville
Dean, Russell,
St. James Bldg.....Jacksonville
Drew, Horace R.,
St. James Bldg.....Jacksonville
Driskell, Simon E.,
458 St. James Bldg.....Jacksonville
Dyrenforth, Lucien Y.,
P. O. Box 2098, W. Bay Annex,
Jacksonville
Eaton, Paul,
2835 Selma St. Jacksonville
Erwin, Stanley,
1001 Lynch Bldg.....Jacksonville
Ferrara, John D.,
313 Greenleaf Bldg. ..Jacksonville
Field, Thomas S.,
712 Laura St.....Jacksonville
Fort, Frank L.,
201 Medical Arts Bldg..Jacksonville
Gammon, Julian E.,
700 Professional Bldg...Jacksonville
Goodale, Banks H.,
St. James Bldg.....Jacksonville
Gorman, John M.,
Peninsular Life Bldg., Jacksonville
Greene, Ralph N.,
210 LeBlond Bldg.....Coral Gables
Hanson, Henry,
Care Consulado General,
de EE. UU. Guayaquil Ecuador
Hanson, Karl B.,
357 St. James Bldg....Jacksonville
Harrell, D. E.,
St. James Bldg.....Jacksonville
Harrell, O. E.,
St. James Bldg.....Jacksonville
Harris, W. G.,
St. James Bldg.....Jacksonville
Hartman, James H.,
546 Lomax St.....Jacksonville
Henley, Charles F.,
412 St. James Bldg. ...Jacksonville
Henson, Graham E.,
201 St. James Bldg.....Jacksonville
Holden, Gerry R.,
Medical Arts Bldg.....Jacksonville
Holloway, Luther W.,
359 St. James Bldg....Jacksonville
Horne, Hendley F.,
325 W. Duval St.....Jacksonville
Hughes, V. A.,
302 St. James Bldg....Jacksonville
Humphreys, David G.....Fernandina
Ira, Gordon H.,
451 St. James Bldg. ..Jacksonville
Izlar, W. H. Waycross, Ga.
Jelks, Edward,
Riverside Hospital.....Jacksonville
†Jennings, Charles L.,
General Delivery, Winnsboro, S. C.
Johnston, C. W.,
355 St. James Bldg....Jacksonville
Keisling, Frederick C.,
315 Professional Bldg., Jacksonville
Killinger, R. R.,
St. James Bldg. Jacksonville
King, Fletcher G.,
1855 Laura St.....Jacksonville
Kirby-Smith, J. L.,
1115 Greenleaf Bldg., Jacksonville
Kirk, Wm. W.,
608 Greenleaf Bldg....Jacksonville
Klein, Lawrence A.,
P. O. Box 178 Live Oak
Knauer, W. Jerome,
Buckman Bldg.....Jacksonville
Knight, A. Comer,
Professional Bldg.....Jacksonville
Krueger, F. W.,
450 St. James Bldg....Jacksonville
Laffitte, L. Sydnor,
Medical Arts Bldg.....Jacksonville
Limbaugh, Louie M.,
357 St. James Bldg....Jacksonville
Lipscomb, T. H.,
St. Lukes Hospital Jacksonville
Lovejoy, John,
202 Medical Arts Bldg., Jacksonville
Lyerly, J. G.,
1022 Park St. Jacksonville
McCullagh, William H.,
441 St. James Bldg....Jacksonville
McEuen, H. Bernard,
402-5 St. James Bldg...Jacksonville
§McGinnis, Robert H.,
2063 Oak St.....Jacksonville
McIver, Robert B.,
1108 Greenleaf Bldg. ..Jacksonville
McKenzie, Albert C.,
St. James Bldg. Jacksonville
Manhoff, Ben,
47 W. Duval St. Jacksonville
Manning, Wm. Saunders,
310 Greenleaf Bldg. ..Jacksonville
May, Robert D.,
302 Professional Bldg..Jacksonville
Mendoza, Carl Clifford,
345 St. James Bldg...Jacksonville
Merritt, J. Webster,
2033 Riverside Ave. ..Jacksonville
Milam, Ernest B.,
Medical Arts Bldg.....Jacksonville
Mitchell, George M.,
712 Laura St. Jacksonville
Mitchell, John H.,
300 Professional Bldg...Jacksonville
Moe, Leonard N.,
212 St. James Bldg....Jacksonville
Morris, S. A.,
237 W. Duval St.....Jacksonville
Norris, S. R.,
Medical Arts Bldg. ...Jacksonville
Norwood, J. K.,
211 St. James Bldg.....Jacksonville
Oberdorfer, Aaron Z.,
409 St. James Bldg.....Jacksonville
Oetjen, G. F.,
211 E. Forsyth St.....Jacksonville
Owens, J. H.,
355 St. James Bldg. ..Jacksonville
Palmer, Thomas M.,
1819 Goodwin St. Jacksonville
Parramore, James B.,
P. O. Box 855, Chapel Hill,
North Carolina
Pasco, J. D.,
Medical Arts Bldg.....Jacksonville
Peterson, C. A.,
St. James Bldg. Jacksonville
Peyton, Harry A.,
2033 Riverside Ave.....Jacksonville
Proctor, Harper L.,
325 Peninsular Life Bldg.,
Jacksonville
Quasser, Adolph B.,
352 St. James Bldg....Jacksonville
Ramage, Raymond B.,
219-20 Professional Bldg.,
Jacksonville
Randolph, J. H.,
St. James Bldg.....Jacksonville
Richards, Ferdinand,
614-16 Greenleaf Bldg..Jacksonville
Richardson, George W.,
343 St. James Bldg....Jacksonville
Richardson, Shaler
111 W. Adams St. Jacksonville
Roberts, Earl.....Jacksonville Beach
Rogers, W. W.,
Professional Bldg.....Jacksonville
Rollins, Clarence D.,
Southside General Hospital,
South Jacksonville
Ross, William E.,
St. James Bldg.....Jacksonville
Royce, Clayton E.,
P. O. Box 2098, W. Bay Annex,
Jacksonville
Safer, Jacob V.,
452 St. James Bldg.....Jacksonville
Sanderson, Raymond,
216 Professional Bldg...Jacksonville
Sandusky, C. M.,
28 W. Monroe St.....Jacksonville
Schnauss, Fauntleroy H,
318 Hildebrandt Bldg., Jacksonville
Schnauss, William R.,
312 Hildebrandt Bldg...Jacksonville
Sellers, E. T.,
412 St. James Bldg....Jacksonville

* Deceased. † Honorary Member. § Life Member.

Sengstak, E. P. E. Mandarin
Simpson, J. Knox,
712 Laura St.....Jacksonville
Slaughter, Frank G.,
Riverside Hospital Jacksonville
Stinson, W. M.,
1611 Aberdeen St. Jacksonville
Stollenwerck, A. D.,
2005 Oak St.....Jacksonville
Strumpf, Irving J.,
344 St. James Bldg....Jacksonville
Swift, Edwin C.,
614-16 Greenleaf Bldg., Jacksonville
Taylor, H. Marshall,
111 W. Adams St.....Jacksonville
Teeter, E. H.,
305 St. James Bldg....Jacksonville
Thomas, Robert Y. H.,
502-6 Lynch Bldg. Jacksonville
Thompson, David C. Azucar
Tyler, L. V.,
San Marco Square, So. Jacksonville
Upchurch, N. A.,
City Board of Health..Jacksonville
Vallotton, J. Ralph,
214 S. Palmetto Ave..
Daytona Beach
VanSchaick, H. D.,
210 St. James Bldg....Jacksonville
Veal, Ernest W.,
25 Miami Road ...So. Jacksonville
Waas, Frederick J.,
Professional Bldg.....Jacksonville
Washburn, Clayton D.,
St. James Bldg.....Jacksonville
Watt, E. C.,
613 Greenleaf Bldg. ...Jacksonville
Wilcox, C. R.,
712 Laura St.....Jacksonville
Wilkinson, A. H.,
313 Professional Bldg., Jacksonville
Wilson, A. K.,
334 St. James Bldg., Jacksonville
Wilson, J. F.,
310 Greenleaf Bldg. ..Jacksonville
Woolsey, B. F.,
320 St. James Bldg....Jacksonville
Wynn, Robert S.,
305 Consolidated Bldg..Jacksonville

ESCAMBIA COUNTY MEDICAL SOCIETY (DISTRICT "A")

Ames, Allen M., President,
206 Blount Bldg. Pensacola
Turberville, J. I., Vice-President,
Century
Hoffman, James M., Sec'y-Treasurer,
6 W. Chase St.....Pensacola
Anderson, W. E.,
511 Am. Natl. Bk. Bldg., Pensacola
Bell, John D.,
505 Blount Bldg.....Pensacola
Born, Charles C.,
513 Blount Bldg.....Pensacola
Bryans, Herbert L.,
21½ E. Wright St.....Pensacola
Daniels, J. P.,
321 Brent Bldg. Pensacola
Dodson, M. W.,
P. O. Box 57.....Alaflora, Ala.
Fellows, J. H.,
Brent Bldg. Pensacola
Fisher, Luther C., Jr.,
513 Amer. Natl. Bk. Bldg.,
Pensacola
Gachet, N. L. Century
Haisfield, A. R.,
311 Blount Bldg.....Pensacola
Haisfield, H. B.,
311 Blount Bldg.....Pensacola
Heinberg, Chas. J.,
506 Blount Bldg. Pensacola
Hogan, Cecil M.,
2151 Pearl St.....Jacksonville
Holley, John C. Milton
Kennedy, S. G.,
511-12 Am. Natl. Bk. Bldg.,
Pensacola
Lischkoff, M. A.,
Blount Bldg. Pensacola
McGuire, J. J.,
Pensacola Hospital.....Pensacola
McLane, J. N.,
204 W. Brainard St.....Pensacola
*McMillan, D. W.,
Scotland House Pensacola
McSween, J. C. Pensacola
Middlebrooks, Violet,
505 Amer. Natl. Bk. Bldg.,
Pensacola
Mock, A. E.,
211 Blount Bldg. Pensacola
Nobles, Robert G.,
Blount Bldg.....Pensacola
Nobles, V. R.,
Blount Bldg.....Pensacola
Nobles, W. D.....Pensacola
Payne, W. C.,
Blount Bldg. Pensacola
Pickett, W. H.,
St. Bd. of Health Bldg., Pensacola
§Pierpont, Juriah H.,
511 Amer. Natl. Bk. Bldg.,
Pensacola
Quina, M. E.....Pensacola
Stokes, Thos. H.,
Theisen Bldg. Pensacola
Sullivay, Rosa L.,
1016 W. Chase St.....Pensacola
Thames, Rufus Milton
Turberville, John S.....Century
Turner, John B.,
(Santa Rosa County) Bagdad
Webb, Carol C.,
210-11 Blount Bldg.....Pensacola
White, Alvyn W.,
P. O. Box 1345 Pensacola

HILLSBOROUGH COUNTY MEDICAL SOCIETY (DISTRICT "D")

Blake, Wm. C., President,
419 Citizens Bk. Bldg.....Tampa
Black, Robert C., Vice-President,
101 San Ever St. Plant City
Grable, James S., Sec'y-Treasurer,
811 Citizens Bk. Bldg. Tampa
Adamo, Frank S.,
Box 1626 Tampa
Adamson, William P.,
610 Citizens Bank Bldg.....Tampa
Alsobrook, J. W.,
120 N. Collins St.....Plant City
Andrews, C. A.,
715 Citizens Bank Bldg.....Tampa
Austin, Edgar Plant City
Barker, Frank T.,
302 Krause Bldg.....Tampa
Bartlett, Chas. W.,
310 First Natl. Bk. Bldg.....Tampa
Beyer, A. R.,
P. O. Box 527.....Tampa
Bidwell, A. M.,
401 First Natl. Bk. Bldg.....Tampa
Bitzer, Emory W.,
815 Citizens Bank Bldg.....Tampa
Blackmon, H. J.,
Citizens Bank Bldg.....Tampa
Boling, John R.,
1207-11 First Natl. Bk. Bldg.,
Tampa
Bottari, Giulio C.,
1202-4 1st Natl. Bk. Bldg...Tampa
Bradshaw, Virgil M.,
316 Citrus Exchange Bldg..Tampa
Brown, H. O.,
215 Madison St. Tampa
Butchart, T. R.,
804 Grand Central Ave.....Tampa
Carlton, Leland F.,
805 Citizens Bank Bldg.....Tampa
Carter, E. F.,
1903 Grand Central Ave.....Tampa
Chandler, J. C.,
410 Citrus Exchange Bldg...Tampa
Coleman, John A.,
105 N. Collins St. Plant City
Cook, George L.,
442 W. Lafayette St.....Tampa
Cook, H. M.,
107 Parker St.....Tampa
Cowart, J. T.,
1111 Citizens Bank Bldg. ...Tampa
Crum, J. W.,
413 Central Office Bldg.....Tampa
Dickinson, J. C.,
304 Citizens Bk. Bldg.....Tampa
Dominguez, J. A.,
P. O. Box 5745 Tampa
Draper, A. D.,
5607 Florida Ave. Tampa
Duke, Roncie R.,
708 Citizens Bank Bldg.....Tampa
Duncan, W. P.,
803 Tampa Theatre Bldg....Tampa
Dyer, W. H.,
1801½ 22nd St. Tampa
Efird, Lester J.,
1019 W. Platt St.....Tampa
Ely, R. A.,
404½ Zack St.....Tampa
Estes, J. L.,
815 First Natl. Bk. Bldg.....Tampa
Ethcredge, S. H.,
706 Franklin St.....Tampa
Ferlita, Americo James,
2512 15th Ave. Tampa
Ferrante, G. C.,
205 Zack St. Tampa
Forbes, Sherman B.,
409 Citizens Bank Bldg.....Tampa
Garcia, Louis J.,
442 W. Lafayette St. Tampa
Garcia, Parsons M.,
P. O. Box 7224 West Tampa
Gilbert, Elsie,
6508 Central Ave.....Tampa
Gilmer, E. S.,
416 Citizens Bk. Bldg.....Tampa
Gonzalez, A. A.,
1725½ Seventh Ave.....Tampa
Grantham, James M.,
442 Lafayette Arcade.....Tampa
Grimal, A. S.,
O'Reilly 49, 6th Floor,
Havana, Cuba
Guerra, Julio J.,
First Natl. Bk. Bldg.....Tampa
Gyland, Stephen P.,
215 Madison St.....Tampa
*Hardy, G. E. W.,
818 First Natl. Bank Bldg., Tampa
Helms, John S., Jr.,
Box 1856 Tampa
Higgins, Allen F.,
442 W. Lafayette St.....Tampa
Holloway, E. W.,
205 7th Ave. Tampa
Holton, W. J.,
119 E. Reynolds St. Plant City
Hopkins, Clack D.,
1818 Hills Ave. Tampa
Jefferson, Rollin,
818 First Natl. Bk. Bldg....Tampa
Jensen, Henry J.,
7303 Nebraska Ave.....Tampa
Jobson, A. M. C.,
702 Citizens Bk. Bldg.....Tampa
Knauf, A. R.,
706 Franklin St.....Tampa
Knight, J. C.,
121 N. Collins St.....Plant City
Knowlton, Horace A.,
922 Citizens Bk. Bldg.....Tampa
Lake, Esley T.,
P. O. Box 8968.....Tampa
Lancaster, Wm. J...Wilmington, N. C.
Lowry, Blackburn W.,
1019 Citizens Bk. Bldg.....Tampa
McClosky, B. Martin,
1801½ 22nd St.....Tampa
McEachern, James R.,
P. O. Box 2214.....Tampa
*McKay, R. H.,
303 Ingraham Bldg. Miami
McLaws, R. B.,
108 E. Columbus Drive.....Tampa
Maguire, Thomas C.,
104 S. Collins St.....Plant City
Maner, George R.,
5309 Central Ave. Tampa
Marcus, Nathan L.,
706 Franklin St. Tampa
Martin, Douglas D.,
442 W. Lafayette St. Tampa
Martorell, Abelardo,
215 Madison St. Tampa
Meighen, Douglas G.,
Citrus Exchange Bldg.....Tampa
Metzger, Frank C.,
916-17 Citizens Bk. Bldg.....Tampa
Mills, Herbert R.,
706 Franklin St.....Tampa
Mills, John H.,
907 17th Ave. Tampa
Minardi, Joseph A.,
2203½ Seventh Ave.....Tampa
Mitchell, L. B.,
P. O. Box 1020.....Tampa
Moore, John T.,
317 Tribune Bldg.....Tampa
Murphey, David R., Jr.,
611 Citizens' Bank Bldg. ...Tampa
Myers, W. C.,
302 Schulte-United Bldg.....Tampa
Nelson, Robert G.,
712 Citizens Bank Bldg.....Tampa
†Oppenheimer, Louis S.,
108 Crescent Place Tampa
Ortega, Rafael,
P. O. Box 5513, Ybor Sta...Tampa
Paniello, Santiago,
P. O. Box 5105, Ybor City..Tampa
Pate, J. C.,
1107-9 1st Nat. Bk. Bldg....Tampa
Patterson, William,
312 Citrus Exchange Bldg...Tampa

* Deceased. † Honorary Member. § Life Member.

Pease, Charles W.,
State Board of Health.....Tampa
Perzia, Anthony P.,
Citizens Bk. Bldg. Tampa
Porro, Gustavo F.,
1915½ 14th St. Tampa
Portocarrero, N. A.,
1915½ 14th St.....Tampa
Rankin, Grover C.,
P. O. Box 1313.....Tampa
Rector, Lee T.,
Citizens Bank Bldg.....Tampa
Roig, Guillermo,
2710 Nebraska Ave. Tampa
Rowlett, William M.,
P. O. Box 786 Tampa
Rudisill, C. A.,
706 Franklin St.....Tampa
Sanchez, Butler H.,
15-17 Lee Bldg. Plant City
*Saxton, J. J.,
2005 Tampa St. Tampa
Scolaro, Joseph D.,
2022½ 7th Ave., Ybor City, Tampa
Shaver, E. F.,
Tampa Theatre Bldg.....Tampa
Smith, Burdette,
411 Citrus Exch. Bldg.....Tampa
Smith, H. Mason,
1019 Citizens Bk. Bldg.....Tampa
Smith, James G., Jr.,
1810 3rd Ave. ...Birmingham, Ala.
Smoak, Edward,
315 Citizens Bank Bldg.....Tampa
Snow, H. O.,
1903 Grand Central Ave.....Tampa
Spengler, Nathaniel L.,
903 Tampa Theatre Bldg.....Tampa
Spoto, Joseph S.,
Hillsborough Co. Health Unit,
Tampa
Stone, Alvord L.,
102 E. Hillsborough Ave....Tampa
Stringer, Sheldon,
P. O. Box 105 Tampa
Taylor, Joseph W.,
Room 807, 706 Franklin St., Tampa
Torbett, R. S.,
409 First Natl. Bk. Bldg.....Tampa
Torretta, Joseph N.,
1725½ E. Bdwy. Tampa
Truelsen, Thomas,
Room 605, 706 Franklin St...Tampa
Vaughan, Cecil,
228 Lafayette Arcade.....Tampa
Vinson, J. C.,
1st Natl. Bk. Bldg.....Tampa
Weekley, Augustine S.,
416 Citrus Exchange Bldg., Tampa
Whitaker, Harper E.,
2112 Watrous Ave. Tampa
Winton, M. R.,
402 Citrus Exchange Bldg...Tampa

JACKSON COUNTY MEDICAL SOCIETY (DISTRICT "A")

Whitaker, C. D., President,
Dekle Bldg. Marianna
Price, C. J.,
Vice-President Alford
Pierce, J. Lewis, Sec'y-Treasurer,
Marianna
Baltzell, N. A.....Marianna
Box, C. C. Graceville
Burns, M. Q.....Blountstown
Chappell, F. V.,
care Johns Hopkins, Baltimore, Md.
Dowling, J. B.....Alliance
Gainey, J. G. Blountstown
Joyner, R. N.,
County Health Officer ...Marianna
McKinnon, Daniel Angus....Marianna
Miller, Redden Lee,
P. O. Box 186.....Graceville
Ryals, C. H.,
R. F. D. No. 1.....Grand Ridge
Wandeck, W. R. Marianna

LAKE COUNTY MEDICAL SOCIETY (DISTRICT "E")

Williams, Rabun H., President,
Theatre Bldg. Eustis
Oetjen, Leroy H., Vice-President,
1028 W. Main St.....Leesburg
Ashton, W. Lee, Sec'y-Treasurer,
Umatilla
Bowen, Louis R.,
P. O. Box 905.....Eustis
Coleman, E. M. Clermont
Colley, Sanford C. Tavares
Conklin, Raymond C.,
141 W. 6th Ave.....Mount Dora
DeVane, W. G. Groveland
Fenn, Harry Todd.....Mount Dora
Hannum, M. M.....Eustis
Hawkins, A. S.,
779 Montrose St.....Clermont
Holland, Howard G.,
1112 W. Main St.....Leesburg
Morrison, Harry K.,
601 W. Magnolia Leesburg
Strickland, Edgar E. Mt. Dora
Tyre, C. McK.....Eustis
Wood, Will L. Mt. Dora

LEE COUNTY MEDICAL SOCIETY (DISTRICT "D")

Grace, William H., President,
Box 907 Ft. Myers
Newton, Robley D., Vice-President,
Ft. Myers Beach Hotel...Ft. Myers
Jones, H. Quillian, Sec.-Treasurer,
18-20 Leon Bldg. Ft. Myers
Bartleson, Fred Ft. Myers
Bostelman, Ernest,
201 Pythian Bldg.....Ft. Myers
Johnson, M. F. Box 1266, Ft. Myers
Longbrake, Guy,
308 Second St.....Ft. Myers
Merrick, C. Gordon,
26 Leon Bldg.....Ft. Myers
Stipe, Harvie J.,
39 Earnhardt Bldg. Ft. Myers
Whisnant, Baker,
3 Leon Bldg.....Ft. Myers

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY (DISTRICT "A")

Godard, Robert Fain, President,
Key Bldg. Quincy
*Beggs, John Miller, Vice-President,
Fla. State Hosp.....Chattahoochee
Wilkinson, B. A., Sec'y-Treasurer,
Telephone Bldg. Tallahassee
Barnes, Benjamin F.....River Junction
Brevard, E. M.,
Lively Corner.....Tallahassee
Brinson, John B.,
Dogwood St.....Monticello
Brown, C. W., Jr.,
506 Exch. Bank Bldg., Tallahassee
Clements, Ralph M. Chattahoochee
Conter, A. E. Apalachicola
Daves, F. E. Chattahoochee
Davis, Julius C.,
Cor. Jefferson & Adams Sts., Quincy
Dozier, L. L.....Tallahassee
Dykes, Chapman Carrabelle
Graves, L. J.,
P. O. Box 623.....Tallahassee
Griffin, Taylor W.,
Cor. Jefferson & Adams Sts., Quincy
Gwynn, Geo. H., Jr.,
Telephone Bldg. Tallahassee
Howell, Harry S.,
Blanche Hotel Annex...Lake City
Jenkins, O. W. Chattahoochee
Johnson, A. B. Chautaqua, N. Y.
Johnston, J. Kent.,
Exchange Bk. Bldg.....Tallahassee
Kendrick, Odis G. Tallahassee
Knight, C. M. Chattahoochee
Logie, Arthur J.,
care St. Bd. of Health, Jacksonville
McClure, Herbert A.,
Director Co. Health Unit....Perry
Massey, Wm. W.,
204 N. Madison St.....Quincy
Moor, F. Clifton,
Telephone Bldg.....Tallahassee
Palmer, Henry E.,
408 S. Adams St.....Tallahassee
Pound, J. H.,
349 Fletcher St...Thomasville, Ga.
Rhodes, Bricey M.,
201 S. Monroe St. Tallahassee
Robertson, J. C. Chattahoochee
Rogers, W. D. Chattahoochee
White, Sarah Parker,
217 Sunset Lane Tallahassee
Wilhoit, Sterling E.....Quincy
Williams, J. F. Monticello
Williams, John L. Tallahassee

MADISON COUNTY MEDICAL SOCIETY (DISTRICT "B")

Long, Eustace, President.....Madison
Davis, George O.,
Sec.-Treasurer Madison
Thorpe, E. D. Madison

MANATEE COUNTY MEDICAL SOCIETY (DISTRICT "D")

Hollingsworth, S. G., President,
451 12th St. Bradenton
Larrabee, Chas. Wm., Vice-President,
Larrabee Hospital Bradenton
Harrison, M. M., Secy-Treasurer,
Bradenton
Blake, L. W. Bradenton
Field, Charles H. Bradenton
Floyd, A. J.,
Lloyd-Hughes Bldg.....Palmetto
Gates, Hubbard,
Box 245 Bradenton
Lancaster, B. M. Manatee
McDuffee, T. M. Manatee
Mason, John Franklin.....Bradenton
Sugg, William D.,
Bradenton Bk. Bldg....Bradenton

MARION COUNTY MEDICAL SOCIETY (DISTRICT "B")

Moore, J. N., President,
210-12 Prof. Bldg. Ocala
Lytle, Carl S., Vice-President,
Dunnellon
Cumming, Richard C., Sec'y-Treasurer,
Commercial Bank Bldg.....Ocala
Cammack, K. R.....Gulf Hammock
Chalker, James L.,
719 E. Ocklawaha Ave.....Ocala
Dozier, Henry C.,
9 N. Magnolia St.....Ocala
Ferguson, R. D.,
P. O. Box 802 Ocala
Freeman, Albert H.,
Holder Block.....Ocala
Futch, Thomas A., Jr.,
Commercial Bank Bldg.....Ocala
Gatrell, Henry Fairfield
Hanson, Edwin C. Belleview
†Hood, J. W. Ocala
Lindner, E. G.....Ocala
Lisk, Percy F.....Ft. McCoy
Martin, Irl E. Ocklawaha
Mimms, Carney W.,
Commercial Bank Bldg. Ocala
Peek, Eugene G.,
Commercial Bank & Trust Bldg.,
Ocala
Russell, Ralph E.....Ocala
Scott, E. L., 114 S. Main St.....Ocala
Slaughter, T. K. Wildwood
Strange, J. L.....McIntosh
Wallis, Thomas H.,
104 S. Magnolia St. Ocala
Watt, H. F., Box 146 Ocala

MONROE COUNTY MEDICAL SOCIETY (DISTRICT "F")

Galey, Harry C., President,
532 Fleming St. Key West
Pintado, Nilo C., Vice-President,
412-13 Postal Bldg.....Miami
Warren, William R., Sec'y-Treasurer,
511 Eaton St.....Key West
DePoo, Julio J.,
330 Duval St. Key West

ORANGE COUNTY MEDICAL SOCIETY (DISTRICT "E")

Sinclair, W. E., President,
Clinic Bldg. Orlando
Harms, F. H., Vice-President,
64 N. Court St. Orlando
Pines, John A., Secretary,
106-10 E. Central Ave.....Orlando
Folsom, Spencer A., Treasurer,
319-22 Exchange Bldg.....Orlando
Anderson, Claude,
1400 E. Church St. Orlando
Andrews, M. M., Box 1817.....Orlando
Beach, M. L.,
Fla. Bk. Bldg. Orlando
Beardall, Harold M.,
147 E. Church St.....Orlando
Brame, Dorothy D.,
316-18 Exchange Bldg.....Orlando
Buff, Julian H.,
49 N. Orange Ave.....Orlando
Burks, B. Auxford,
108 E. Park Avenue...Winter Park
Butler, Paul T.,
23 Autrey Arcade.....Orlando
Carson, Russell B.,
311 Exchange Bldg Orlando
Chappell, John R.,
P. O. Box 1370 Orlando

* Deceased. † Honorary Member. § Life Member.

Chiles, J. H. Holopaw
Christ, Calvin D.,
P. O. Box 1137.....Orlando
Christie, Gerard E.,
P. O. Box 151.....Titusville
Collins, Chas. J.,
209-12 Exchange Bldg. Orlando
Day, Horace A.,
209-12 Exchange Bldg.....Orlando
Dodds, William Henry,
11th St. & Pa. Ave.....St. Cloud
Gardner, J. F. Winter Park
Gray, Frank D.,
11 Lucerne Circle Orlando
Gwathmey, G. Tayloe,
710 Fla. Bank Bldg.....Orlando
Gwynn, H. W.,
Clinic Bldg.....Orlando
Hart, Ruth S. Winter Park
Henderson, R. P.,
215 Exchange Bldg. Orlando
Hoffmann, C. D.,
120 E. Robinson Ave.....Orlando
Hotard, Roland F.,
226 E. Park Ave.....Winter Park
Ingram, L. C.,
P. O. Box 1711.....Orlando
Jewitt, Eugene L.,
11 Lucerne Circle Orlando
†Johnston, Colonel Geo. C.,
P. O. Box 272.....Orlando
Johnston, Hewitt,
P. O. Box 2002 Orlando
Knowles, Harold S.,
215 Exchange Bldg. Orlando
Lawrence, E. J. Winter Garden
Lawson, Ben Hill.....Winter Garden
†Lewis, P. M.,
P. O. Box 346 Orlando
Lynn, C. W.,
Fla. Sanitarium.....Orlando
McBride, Thomas E.....Apopka
McEwan, Duncan T.,
106-10 E. Central Ave.....Orlando
McEwan, John S.,
106-10 E. Central Ave.....Orlando
McGugan, Arthur,
646 Seminole Drive...Winter Park
Mallory, Meredith,
P. O. Box 1011.....Orlando
Morton, B. Rosalie Slaughter,
Winter Park
Neal, Thomas Albert,
P. O. Box 321 Orlando
Oertel, H. B. Osceola
Orr, Louis McDonald,
311 Exchange Bldg.....Orlando
Osincup, Gilbert S.,
300 E. Colonial Drive.....Orlando
Page, W. Grady,
State Bank Bldg.....Orlando
Quillman, Frank L.,
11 S. Main St. Winter Garden
Redding, John L.,
209 S. Orange Ave.....Orlando
Ricker, Samuel F.,
33 E. Livingston Ave.....Orlando
Rivers, T. M. Kissimmee
Rue, Doran T.,
311 Exchange Bldg. Orlando
Shoemaker, Samuel A.,
30 E. Church St.....Orlando
Spiers, Wm. Henry,
P. O. Box 1712 Orlando
Sutter, Leroy M.,
140 N. Orange Ave. Orlando
Taylor, B. E.,
Florida Sanitarium.....Orlando
Weed, Walter Alva,
2nd Floor, Exchange Bldg., Orlando
White, Roland T.,
211 S. Rosalind Ave.....Orlando
Williamson, Carolyn G.,
310 E. South St. Orlando
Wood, Robert G.....St. Cloud

PALM BEACH COUNTY MEDICAL SOCIETY (DISTRICT "F")

Rozier, L. McK., President,
411-14 Comeau Bldg.,
W. Palm Beach
Heath, Guy W., Vice-President,
409-11 Harvey Bldg.,
W. Palm Beach
Netto, Lloyd J., Secretary,
415 Comeau Bldg., W. Palm Beach
Herpel, Frederick K., Treasurer,
P. O. Box 1057.....W. Palm Beach
Arnold, Wilbur Ogden,
P. O. Box 1735.....W. Palm Beach
Baldwin, R. Henry,
1101 Harvey Bldg...W. Palm Beach
Binkley, John Frey,
1206 Harvey Bldg...W. Palm Beach
Blair, William M.,
424 Comeau Bldg...W. Palm Beach
Boynton, Charles E., Jr.,
1023 Comeau Bldg., W. Palm Beach
Brantley, Grady H.,
P. O. Box 336.....Lake Worth
Clarholm, Victor,
Harvey Bldg. W. Palm Beach
Cooley, Roy Oscar,
P. O. Box 1735.....W. Palm Beach
Cram, George E.,
223 Sunset Ave. Palm Beach
Creel, Charles E.....Pahokee
Davis, K. M.,
Central Arcade Delray Beach
Dawson, George M.,
P. O. Box 1836.....W. Palm Beach
Denison, Raymond C.,
521 Lake Ave.....Lake Worth
Ebert, J. William,
Harvey Bldg. W. Palm Beach
Elarbee, George W. Pahokee
Fleming, Samuel Ward,
417 Harvey Bldg...W. Palm Beach
Gardner, William H.,
Comeau Bldg.....W. Palm Beach
George, Wm. W.,
1116 Harvey Bldg., W. Palm Beach
Gill, Richard S.,
Box 2004 W. Palm Beach
Hazen, Olen B.,
Comeau Bldg. W. Palm Beach
Henry, Gordon F.,
305 Citizens Bldg....W. Palm Beach
Jackson, Noah,
312 Hibiscus St.....W. Palm Beach
Johnson, Vesey M.,
Good Samaritan Hospital,
W. Palm Beach
King, Graham W., Jr.,
Love Bldg. Delray Beach
Lewis, Gaylord,
916 Harvey Bldg...W. Palm Beach
Miller, Alice R.,
418 Fern St.....W. Palm Beach
Newnham, J. A.,
511 Harvey Bldg....W. Palm Beach
Nowling, James C.,
309 Harvey Bldg....W. Palm Beach
Papot, Grace E.,
811 Harvey Bldg....W. Palm Beach
Pittman, J. H.,
P. O. Box 552.....W. Palm Beach
Powell, J. A.,
627 So. Olive.....W. Palm Beach
Randall, Floyd H.,
Boca Raton Club.....Boca Raton
Rowe, Alva L.....Lake Worth
Sayad, William Y.,
1215 Harvey Bldg..W. Palm Beach
Schiffli, O. F. Clewiston
Shackelford, C. W.....W. Palm Beach
Shackelford, W. L. W. Palm Beach
Sory, B. B., Jr.,
Brazilian Court Hotel, Palm Beach
Sory, James R.....Lake Worth
Stone, Vale D.,
Harvey Bldg. W. Palm Beach
Van Landingham, William E.,
P. O. Box 758.....W. Palm Beach
Wakefield, Harry A.,
810 Comeau Bldg...W. Palm Beach
Waller, Constantine B.,
Harvey Bldg. W. Palm Beach
Warren, Hobart E.,
Phipps Plaza.....Palm Beach
Weems, Nat. M.....Boynton
Whitman, Frank S.,
512 Comeau Bldg....W. Palm Beach
Wilber, A. B.,
170 Seaview Ave.....Palm Beach
Williams, Wm. Chas., Jr.,
402 Comeau Bldg...W. Palm Beach
Young, Wilburn C. Canal Point

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY (DISTRICT "B")

Sistrunk, Robert D., President,
Dade City
Harvard, S. C., 1st Vice-President,
Brooksville
Hudson, P. J.,
2nd Vice-President ..Crystal River
Bourke, John J.,
Secy.-Treas. Dade City
Bradshaw, J. T. San Antonio
Cannon, Augustus B.....Lacoochee
Coogler, A. C. Brooksville
Creekmore, George R.,
112 N. Main St.....Brooksville
Dame, George A.,
241 Main St.....Inverness
Dame, Leland H.,
Dist. Health Officer, W. Palm Beach
Jones, W. Wardlaw.....Dade City
Mills, David A.....Zephyrhills
Moon, William B.....Crystal River

PINELLAS COUNTY MEDICAL SOCIETY (DISTRICT "D")

Kauffman, Frank E., President,
Coachman Bldg Clearwater
Nettles, Robbins, 1st Vice-President,
402-5 Coachman Bldg. ..Clearwater
Heibner, E. A., 2nd Vice-President,
Power & Light Bldg.,
St. Petersburg
McConnell, W. C., Sec'y-Treas.,
1005 Equitable Bldg., St. Petersburg
†Albaugh, Andrew P....Tarpon Springs
Anderson, Arnold S.,
712 Power & Light Bldg.,
St. Petersburg
Anderson, C. O.,
333 Third St. N.....St. Petersburg
Anderson, J. M.,
333 Third St. N.....St. Petersburg
Anderson, Wm. D.....Tarpon Springs
Bieker, Annette M.,
825 Power & Light Bldg.,
St. Petersburg
Bieker, Arthur J., Jr.,
360 4th St. S. St. Petersburg
Black, M. Eldridge,
311 Coachman Bldg.....Clearwater
Bowen, John T.,
Coachman Bldg. Clearwater
Bradford, W. H.,
U. S. Veterans Hospital..Bay Pines
Center, R. H.,
Coachman Bldg.....Clearwater
Cooper, J. H.,
First Natl. Bk. Bldg., St. Petersburg
Davis, W. M.,
342 First Ave. N.....St. Petersburg
Dawson, S. A.,
870 Seventh Ave. N., St. Petersburg
Dickerson, L. B.,
Williamson Bldg.....Clearwater
Dicks, Reid E.,
632 22nd St. S.....St. Petersburg
Echard, T. B.,
203 Equitable Bldg., St. Petersburg
Farber, C. K.,
1110 Highland St. S., St. Petersburg
Farber, William P.,
807 Power & Light Bldg.,
St. Petersburg
Feaster, O. O.,
St. Anthony's Hosp., St. Petersburg
Frederick, A. R.,
614 Power & Light Bldg.,
St. Petersburg
Funk, Neil E.,
702 Power & Light Bldg.,
St. Petersburg
Gable, Linwood M.,
Power & Light Bldg., St. Petersburg
Gable, Nonie Wilson,
Health Department,
175 Fifth St. N.....St. Petersburg
Gable, Nonie Worth,
706 Power & Light Bldg.,
St. Petersburg
Gowe, Donald F.,
1252 Corona St.....Denver, Col.
Green, T. H.,
614 Hall Bldg.....St. Petersburg
Griffin, Thos. R.,
Power & Light Bldg., St. Petersburg
Groves, W. H.....Clearwater
Guinand, P. H.,
Jackson Bldg. Clearwater
Harden, W. W.,
814 1st Natl. Bk. Bldg.,
St. Petersburg
Hardenbergh, John A.,
404 Power & Light Bldg.,
St. Petersburg
Hebard, C. E.,
Fla. Natl. Bk. Bldg., St. Petersburg
Herring, John A.,
259 3rd St., N. St. Petersburg
Horne, Lester W.,
Power & Light Bldg., St. Petersburg
Jennings, Frank S.,
248 Third St. N.....St. Petersburg
Knowlton, R. H.,
Power & Light Bldg., St. Petersburg
Lambdin, L.,
332 4th St., N.....St. Petersburg

* Deceased. † Honorary Member. § Life Member.

Langley, Francis H.,
614 Times Bldg.....St. Petersburg
LeBreton, Prescott,
American Legion Hospital,
St. Petersburg
Leith, R. B.,
201 Snell Bldg.....St. Petersburg
Lochner, G. M.,
406 Power & Light Bldg.,
St. Petersburg
Lustig, Emil,
500 Seventh Ave. N., St. Petersburg
MacCordy, Earl C.,
307 Equitable Bldg., St. Petersburg
Marr, Norval M.,
812 Power & Light Bldg.,
St. Petersburg
Mease, J. A., Jr., *
Virginia Avenue.....Dunedin
Melville, E. J.,
335 Third Ave. N.....St. Petersburg
Miller, George E.,
411 Third Ave. N.....St. Petersburg
Mills, Alvin L.,
308 Fla. Natl. Bk. Bldg.,
St. Petersburg
Moeller, M. W.,
1077 15th Ave., N., St. Petersburg
Murphy, Ralph D.,
P. O. Box 82.....St. Petersburg
Nelson, Orville N.,
U. S. Veterans Hosp.....Bay Pines
Nickle, M. A.,
503-5 Coachman Bldg...Clearwater
O'Brien, R. K.,
E. 105 5th Ave., N., St. Petersburg
†Osgood, G. E.,
4823 15th St. N.W.,
Washington, D. C.
Owen, W. S.,
518 Power & Light Bldg.,
St. Petersburg
†Peabody, J. D.,
456 Third St. N.....St. Petersburg
Post, Wm. G., Jr.,
814 Power & Light Bldg.,
St. Petersburg
Prather, B. T.,
701 Fla. Natl. Bk. Bldg.,
St. Petersburg
Quicksall, J. Braden,
211 Taylor Arcade, St. Petersburg
Quicksall, W. E.,
222 Taylor Arcade...St. Petersburg
Rogers, H. M.,
Equitable Bldg. St. Petersburg
Roope, A. P.,
1727 8th St. N. St. Petersburg
Roush, Franklin W.,
4689 Lakeview Ave., St. Petersburg
Rudolph, C. C.,
512 Power & Light Bldg.,
St. Petersburg
Simcox, Lawrence,
201 Third St. N.....St. Petersburg
Smithset, S. P.....Sutton's Bay, Mich.
Solomon, H. D.,
Power & Light Bldg. St. Petersburg
Stevens, Ralph E.,
Fla. State Hospital..Chattahoochee
Strickland, J. A.,
712 Power & Light Bldg.,
St. Petersburg
Stuart, M. H.,
208 Equitable Bldg., St. Petersburg
Timberlake, Gideon,
6th Floor Times Bldg.,
St. Petersburg
Wade, H. W.,
512 Power & Light Bldg.,
St. Petersburg
White, Benj. L.,
202 First Natl. Bk. Bldg.,
St. Petersburg
Whitford, Grace R.....Ozona
Williams, C. A.,
P. O. Box 975.....St. Petersburg
Winchester, H. E.,
P. O. Box 448.....Dunedin
Wood, Alvin J.,
208 Equitable Bldg., St. Petersburg
Wright, Claude B.,
214 Equitable Bldg..St. Petersburg
Wylie, Leroy A.,
210-13 Medical Arts Bldg.,
St. Petersburg

POLK COUNTY MEDICAL SOCIETY (DISTRICT "D")

Clark, Samuel A., President,
802 Marble Arcade Bldg.,
Lakeland
Shafer, W. W., Vice-President,
Haines City
Boulware, James R., Jr., Sec.-Treasurer,
P. O. Box 367.....Lakeland
Alexander, Omer R.,
Marble Arcade Lakeland
Besenbruch, Peter W.,
Orange St. Davenport
Bird, D. Paul,
Box 414 Lakeland
Bond, Benjamin J.,
301-2 Taylor Bldg., Winter Haven
Bosworth, Joe Marvin, Jr.,
Box 1202 Lakeland
Carefoot, G. M. Ft. Meade
Cline, R. L.,
P. O. Box 462.....Lakeland
Cordes, H. B., Box 84.....Frostproof
Early, C. S,
Spencer-Futch Bldg.....Lakeland
Freeman, G. C., Box 1202....Lakeland
Fuller, Henry Mulberry
Gilbert, R. E.,
19 Postal Arcade.....Winter Haven
Gilchrist, J. G.,
P. O. Box 744.....Bartow
Griffin, J. D.,
203 Hartzell Lakeland
Hargrove, Julian Leo,
Polk County Hospital.....Bartow
Harness, A. J.,
417 McDonald St. Lakeland
Harris, Esau A. Brewster
Horton, Waldo,
539 Ave. B., N. W....Winter Haven
Hughes, Robt. Lee,
225 E. Main St. Bartow
Hurlburt. C. J.....Bartow
Irons, F. E. Winter Haven
Koon, Alpheus C.,
117 So. Tenn. Ave.....Lakeland
Lancaster, L. L.,
Taylor Bldg. Winter Haven
Lester, John G.,
P. O. Box 548.....Lakeland
Lindsey, Sherrod A.....Ft. Meade
Lowry, James B.,
P. O. Box 66.....Nichols
McMurray, James W.,
Dist. Med. Officer.....Marianna
Martin, Emmett E.,
Wray Bldg. Haines City
Mooty, Ross H. Winter Haven
Murphy, C. H.....Bartow
Murphy, H. K.,
Polk & Main Sts.....Mulberry
Newman, Heber P. Bartow
Nicholson, L. B.,
307 Marble Arcade Lakeland
Overstreet, G. C.,
Marble Arcade.....Lakeland
Peacock, William F.,
Barnett-Embry Bldg.....Bartow
Pearce, C. C. Mulberry
Pennington, B. Y.....Lake Wales
Ragsdale, V. H.,
A. A. C. Co. Hospital.....Pierce
Roberts, Tenney H.,
328 N. Florida Ave.....Lakeland
Sherman, Wm. E.,
716 W. Central Ave..Winter Haven
Simmons, T. G.,
Corlett Bldg. Auburndale
Simpson, W. T.,
Taylor Bldg. Winter Haven
Smith, Samuel F.,
P. O. Box 628.....Lakeland
Stetson, A. G. C.,
Sullivan Bldg.....Lakeland
Sullivan, Raleigh R.,
1006 Marble Arcade.....Lakeland
Tillis, W. L.,
502 Marble Arcade Bldg., Lakeland
Tinkler, B. R. Lake Wales
Tomlinson, J. P., Jr.,
Alcoma Bldg. Lake Wales
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Alcoma Bldg. Lake Wales
Vaughn, John W.,
P. O. Box 475.....Lakeland
Watson, Herman,
P. O. Box 944.....Lakeland
Watson, S. Edgar, Box 944, Lakeland
Wilhoyte, R. E. Lake Wales
Williams, E. L.....Ft. Meade
Wilson, Cecil H. Bartow
Wilson, John F., Jr.,
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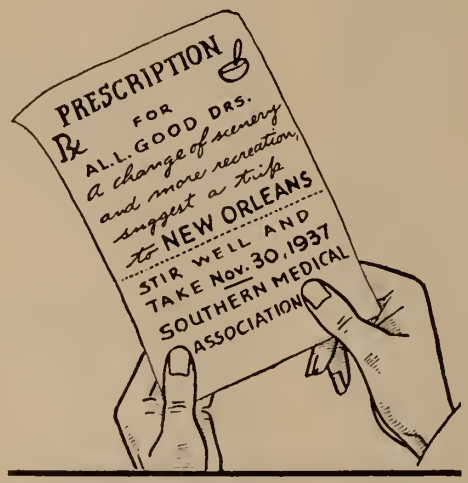
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Meeting Dates:

NOV. 30, DEC. 1, 2, 3, 1937
NEW ORLEANS

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS	
			Date	Place
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville		
Brevard	W. C. Page, M.D., Cocoa	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies
Broward	George S. McClellan, M.D., Pompano	Oliver C. Brown, M.D., 915 Sweet Bldg., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City
Dade	R. N. Burch, M.D., 1774 S.W. Eigbtb St. Miami	Walter C. Jones, Jr., M.D., 802 Huntington Bldg. Miami	1st Friday 8:30 P.M.	Elks Club
DeSoto-Hardee-Highlands	Gordon H. McSwain M.D., Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies
Duval	Kenneth A. Morris, M.D., 237 W. Duval St. Jacksonville	George W. Croft, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville
Escambia	J. C. McSween, M.D., Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola
Hillsborough	George L. Cook, M.D., 443 W. Lafayette Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa
Jackson	C. H. Ryals, M.D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna
Lake	LeRoy H. Oetjen, M.D., Leesburg	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis
Lee	H. Quillian Jones, M.D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M.D. 39 Earnbardt Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers
Leon-Gadsden-Liberty-Wakulla-Jefferson	L. L. Dozier, M.D., Tallahassee	B. A. Wilkinson, M.D., Telepbone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison		
Manatee	S. G. Hollingswortb, M. D. 451 12tb. St, Bradenton	M. M. Harrison, M. D. Bradenton	3rd Tuesday 7:00 P. M.	Wbitfield Country Club Bradenton
Marion	Ralph E. Russell, M.D., Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies
Orange	F. H. Harms, M.D., 64 No. Court St. Orlando	Hewitt Jobnston, M.D., Box 2002 Orlando	3rd Wednesday 8:30 P.M.	Varies
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach
Pasco-Hernando-Citrus	W. Wardlaw Jones, M.D., Dade City	G. R. Creekmore, M.D., Brooksville	2nd Tbursday 7:00 P.M.	Varies
Pinellas	N. M. Marr, M.D 812 Power & Ligbt Bldg., St. Petersburg	W. C. McConnell,, M. D. 1005 Equitable Bldg. St. Petersburg	1st. and 3rd. Friday 6:30 P.M.	Sbrine Club St. Petersburg
Polk	R. E. Gilbert, M.D., 19 Postal Arcade, Winter Haven	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland
Putnam	H. A. Jobnson, M. D. Palatka	F. Emory Bell, M.D., Palatka	2nd Tbursday 7:00 P.M.	James Hotel, Palatka
St. Johns	Cbarles C. Grace, M.D., East Coast Hospital St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies
Sarasota	Arthur O. Morton, M.D., Commercial Court Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies
Taylor	J. C. Ellis, M.D., Perry	J. L. Weeks, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Cbowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies

NOTE—Secretaries: Please submit information to complete the above schedule.

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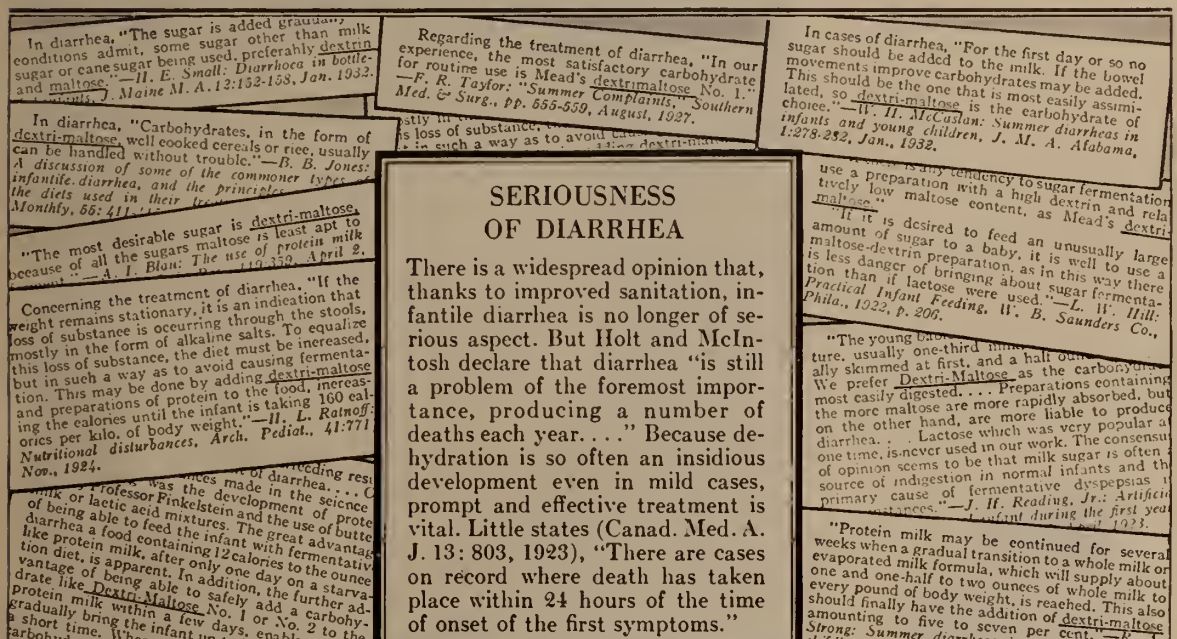
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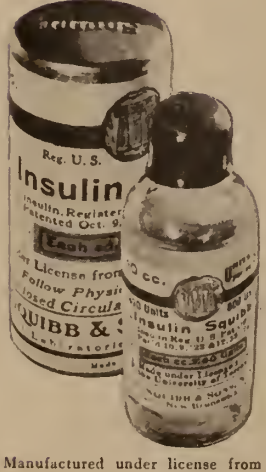
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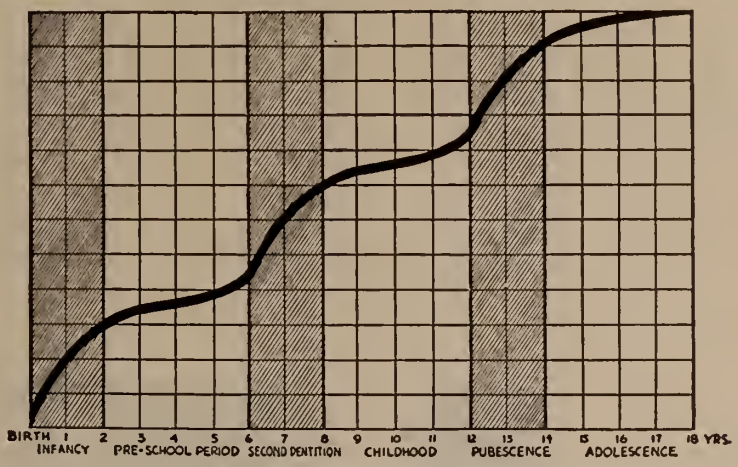
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XXIII | Jacksonville, Florida, July, 1936 | Number 1

RADIO BROADCASTS—WRUF

The Committee on Public Relations of the Florida Medical Association has been very active during another year. For the convenience of those who desire to refer to the text of broadcasts, the Public Relations Committee has requested the editor to publish the broadcasts in one number of the Journal. The July number has been designated for this year and the chairman of the Public Relations Committee has assembled the broadcasts for publication in this issue. He has also prepared an editorial on this subject which appears in this Journal.

Before this decision was made, Doctor J. S. Turberville's broadcast on "Introduction to Medical Economics I," was published in the March, 1936, Journal. With the exception of Doctor Turberville's broadcast, the entire series for this year is reproduced in this number.

Two broadcasts of earlier dates, not heretofore published, are also included, one by Dr. J. Ralston Wells and the other by Doctor Henry C. Dozier. These two broadcasts appear following the 1936 series.

INTRODUCTION TO MEDICAL ECONOMICS II*

George C. Tillman, M.D.,
Gainesville.

Medicine is today practiced in a society dominated by industry and commerce and consequently a knowledge of that society and of its economics is essential to an understanding of the economics of medical service.

"Effective demand" which determines price is demand accompanied by purchasing power and is entirely different from the demand of need or desire. Economists teach that only "effective demand" can increase the supply, but this is not wholly true of medical service. Payments for medical service come from and are limited by primary incomes received in industry, commerce, agriculture, and banking. The number and amounts of the incomes in each locality create the broad limits of the "effective demand" for medical service. The economic problems of medicine are questions of adjusting the payment for medical care to the various incomes of the classes, and popular knowledge of scientific progress brought recognition that the needs (potential demand) for medical services are much the same in all classes, while the purchasing power (effective demand) is widely different and the current problem is a discussion of medical economics and proposals for changes in methods of distribution of medical services in the presence of a very large class of persons with low incomes; their need for service is as great as that of the larger income group and their needs have created all the problems of free clinics, free hospital care, sick insurance, infant and maternal welfare, industrial medicine, and an appreciable part of the problems dealing with the extension of public health and school medical service. These problems would disappear if a minimum family income of $2,000 was promoted; one-half the families in the U. S. now have incomes less than $2,000 and illness causes them to be deprived of the other necessities in order to purchase medical services at the regular rates; neither are they able to purchase food, housing, clothing and recreation essential to maintain good health. This type is essentially an economic problem and not medical and will not be solved by any reorganization of the long tested and approved forms of medical practice.

The distribution of physicians is in direct ratio to the number of persons filing income tax reports in a community. The same is true of hospital facilities and it is self-evident that the ability to purchase goods or services in order to satisfy any need, depends on the income. Physicians are called upon to care for the low group for inadequate fees or without fees; this being unfair as taxes and the expenses of the physician are not subject to reduction although he is caring for the community's poor and at an actual expense while other groups, the storekeeper, landlord and others are not called upon directly to contribute to the low income group. In addition, the physician contributes his knowledge in pre-

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, March 8, 1936.

venting communicative disease in a community, thereby destroying a portion of the "market" for medical services, a service that no other "merchant" in a community provides without remuneration. Also, he daily safeguards health, cares for the indigent as well as many who due to lax laws are allowed to defraud him of his gains.

The most pressing medical problems are primarily economic and call for cooperation of the economist in their analysis, and are not to be considered as merely paying for medical service rather than for diagnosis and treatment and cannot be handled as the manufacture and sale of a commodity, and the remedies should be applied to these problems by a trained medical economist rather than to make an argument that medical service is the first necessity requiring socialized support. Engle's law, that the smaller the family the greater the proportion spent for food, continues to be proven by recent research; while the same research shows that on incomes under $1,200 annually, $17.40 was spent for medical service, and on an income of $2,000 to $3,000 it was $31.87, while $400 more per year was spent for food.

During the early days the Federal Emergency Relief urged the need for medical service provided by physicians, without pay, as part of public relief, assuming that medical service takes precedence over other necessities of life; however, as soon as proposals were made for them to pay a nominal fee then the position was completely reversed and they at once maintained that medical service is a sort of "residual necessity" to be provided only after food and clothing if sufficient funds remained.

During an average year about 10% of the population suffer from some illness requiring extended care, a major operation or hospitalization. A low income family is crushed by this expense, but is it justifiable that the entire economic relations of medical care be fundamentally changed to provide for the 90% in order to care for this 10% of one group?

Sickness insurance is not the solution to the problem. In ordinary commercial transactions, insurance is a method of protection against uncertain losses and is incidental to the economic operations, but with sickness insurance it becomes a method of collecting the costs of medical services in advance and administering the distribution of the funds collected for the purchase and control of medical service. Accurate predictions of the amount of illness is impossible and no sickness insurance has been able to set up reserves. Still the losses are not paid in cash but in service, the flexible element is service.

A fire or life insurance company miscalculates its risks; it goes into bankruptcy. A similar situation with sickness insurance is met with a reduced quality of its service and reduces payment to those giving the service. The consumers are unable to judge the quality of medical service, therefore, sickness insurance operates much like a fire insurance company that pays off in counterfeit money whenever its losses exceed its income. Those in favor of sickness insurance avoid a discussion of why they do not pay cash for sickness but instead give medical service.

One has only to study the sick insurance on the continent of Europe. Time will not permit a discussion of their "sixpence" doctors who are seeing patients at approximately 10c each, the price being sufficient for you to well judge the benefits to be derived from such a fee. We contend that any sick insurance should pay in cash, allowing the beneficiary to employ a physician of his or her own choosing, thereby the service rendered will be far superior to that obtained from a low fee or salary paid physician, a representative of an insurance company who is at the same time paying large executive's salaries and economizing on the service rendered. An example nearer home is the contract practice as seen in several localities in our state.

Again no existing system of insurance has so far contributed to the knowledge of preventive medicine.

Your physician is interested in the problem of care for the low salary class; he as a citizen is interested in their material welfare as well as professionally in their health; his national, state, and county medical societies have for the past few years devoted a large amount of time to the study of the problem and are gradually progressing to its solution; his problem is as a citizen as well as a professional man who for time immemorial has carried with expense to himself a group of people who are your problems. The merchant, the banker, or the landlord does not contribute personal service or funds directly for their care and it is with your interest and support that a workable plan can be instituted to care for this problem.

He should be remunerated for personal ser-

vice, he should be consulted, and as an expert with years of training his advice should be sought before radical changes or procedures are undertaken. We may not reach the Utopia of free food, clothing, and sufficient income for all purposes, but neither can we by law or legislation afford to tear down a scientific profession which has its foundation deep in the bedrock of American history from its earliest Colonial days in order to fulfill the theoretical whims of social agitators whose chief claim to importance is self-propelled.

THE COST OF MEDICAL EDUCATION*

HOMER L. PEARSON, M.D.,
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It was inevitable that during the centuries while medicine was becoming integrated from meaningless bits of folk-ways, mysterious superstitions and primitive incantations into an orderly array of logical demonstrable truths, little should be recorded as to the cost of obtaining the information necessary to qualify one as a physician. Moreover, there is consistency in the finding that search for and interpretation of facts bearing on vital processes have been uppermost in the minds of the great teachers and investigators.

There is reason to hope that those qualities which characterized our medical ancestors as indomitable searchers for truths may forever be perpetuated. But in a world of increasing social and economic complexities it is no longer possible to disregard cost. Honesty of purpose and integrity of action will always be high values in character, but there must be a limit to which any educational process should be carried for the individual who must later seek his livelihood from the training thus gained. To be sure, an individual trained in the thinking and investigating process should continue his education throughout life; but his actual college days are usually limited to a degree, by the amount of time and money he feels he can invest and the readiness with which he can later adjust himself with his new equipment.

A series of talks on medical cost is incomplete without a brief study of the cost of medical education and no discussion of the cost of medical education is complete without considering, not only the actual monetary outlay for a four-year university course in medicine but must include premedical education, post-graduate courses of study, the time spent in the pursuit of a medical education and the mental energy expended in obtaining a complete medical education.

When a young man or woman begins the consideration of a life's career, a great many of them must of necessity consider the cost, for not every ambitious youth has a parent or guardian whose funds are sufficient to afford unlimited educational advantages in any field; and our educational costs are slowly becoming so great that many worthy young people are denied the privilege of obtaining the education they most desire. It has often been said, that if one's ambition is great enough, all handicaps can be overcome. That may be true, but in order to overcome one handicap, others are sometimes made greater. For instance, if one's finances are limited to a large degree, he, of necessity, must spend a greater amount of time and energy in order to supplement his inadequate finances.

Then, too, if we are to study the cost of medical care, we must take into consideration the cost of medical education, because any investor of money, time and energy is entitled to a fair return on his investment, so if you will bear with me, I will try to give you a brief statement as to the cost of medical education. Let it be understood that these figures are as nearly accurate as can be obtained at this time. This is not a maximum nor a minimum expense but is an average taken from some thirty-five or forty medical schools.

We shall begin our analysis when the youth finishes high school and has decided upon the study of medicine as a career.

All grade A medical colleges require two years of college work or of premedical training before they will admit one to the medical college. Some require a full college education or a Bachelor's Degree before admission is granted. Therefore it is necessary for our prospective medical student to attend a literary college or university before he can apply for admission to medical college.

The cost of this premedical work varies with the college selected. State universities are usually somewhat less expensive than other institutions but considering room, board, clothes, tuition, fees, traveling expenses, etc., he must

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, March 15, 1936.

have about $75.00 a month to cover these expenses, for nine months. This amounts to $675.00 per year. I am sure that in universities other than state universities, the expense would be greater. For two years at that rate the expense would be $1,350.00. If it is decided to take four years' premedical work, the next two years of college work are slightly more expensive than the first two. An average figure would be $800.00, making the two years cost $1,600.00, or the full four years' course $2,950.00.

This young man or woman is now ready to apply for admission to medical school. Most good schools have a waiting list, or I might say, can take only about 50% of those who apply. Therefore, one must have rather an impressive college record to present with his application in order to gain admission.

A study has been made by the American Medical Association, of the cost of a medical education and as a result of that study it has been estimated that the four years in medical college costs about $1,100.00 a year, or about $4,400.00 for the four years. Still after all this preparation, one is not prepared to begin his medical practice. He has merely laid the foundation so he must now spend from one to three years in a recognized hospital as an interne so that he can study first hand the diagnosis and treatment of human diseases and apply the truths he has learned in college.

Few hospitals that train internes, or young doctors, pay a salary, neither is there any cost to the interne, as he receives his room and board and about enough to pay other actual expenses. There is, however, another year or two or three of time and mental energy which he has devoted to his education.

Let us estimate, if you can, the value of the time spent in training, or the money lost while in college. Immediately upon leaving high school, a youth's time may be worth from $5.00 to $15.00 per week for the first year, with an increase each year, so that at the 6th year, his time should be a great deal more valuable. I am sure then, that an estimate of $15.00 per week for six years would not be too great. This would then be $720.00 a year, or $4,320.00 for six years. After one finishes medical school his time is worth considerably more, estimated at, at least $100.00 each month, for that is about the usual salary paid to young doctors who accept positions in smaller hospitals that do not have the facilities for training that the larger hospitals have. Then two years at that rate would be $2,400.00.

Following a course such as outlined above, should complete the education of a doctor who wishes to do a general practice. However, if he wishes to keep abreast of the time, he must take post-graduate work at frequent intervals. These, of course, are rather expensive and then, too, the value of his time has increased a great deal and he suffers the loss of the time he is away from his practice.

If he should decide to specialize in a particular line, he must take from one to three years' post-graduate work, which is rather expensive. However, our first consideration is of the cost of a medical education, or an education which fits one to do a satisfactory general practice of medicine and surgery and it is briefly summarized as follows:

Two years' premedical work	$ 1,350.00
Four years' medical college work	4,400.00
Estimated value of time spent 6 years	4,320.00
Estimated value of time interne 2 years	2,400.00
Total	$12,470.00
If two additional years are spent in premedical work	1,600.00
An additional year as interne	1,200.00
	$15,270.00

That we estimate is the cost of medical education without counting the cost of post-graduate work. So before one decides definitely to choose such a career, let him first consider the cost and before one criticizes too much, the cost of medical care, let him first consider the investment the doctor has made, not in office equipment, instruments, rent and traveling expenses, etc., but in his preparation alone.

This preparation is made for your benefit. It is made so that the doctor may be better able to diagnose and treat your illness.

(In preparing this address, liberal use has been made of information contained in the publication "The Cost of Medical Education" by Dr. R. G. Leland, Director, Bureau of Medical Economics, American Medical Association.)

MEDICAL RELATIONS UNDER WORKMEN'S COMPENSATION*

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Compensation systems, like other social institutions, were born out of previously existing institutions and are constantly adjusting themselves to meet the strains and stresses of the social environment in which they function. The present system is the result of such adjustments during the last 20 to 25 years. Changes proceed from various sources. State legislatures are frequently called upon to consider amendments. The commissions that interpret this legislation make new regulations constantly. Both the laws and the regulations are the basis of appeals to various courts, whose decisions bring other changes.

Analysis of these changes shows that there are certain very clear and general lines of evolution, the principal ones of which are as follows:

1. A steady increase in the amount of cash compensation granted. This includes increases in the percentage of wages used as a basis for calculating compensation, in the maximum wages which the law fixes as such a base, and in the schedule of compensation.

2. A decrease in the "waiting period" after an accident, during which no compensation is paid but during which medical aid is almost always granted.

3. An increase in the scope of coverage either in the number and character of industries included or in the nature of injuries compensated—such, for example, as occupational diseases.

4. A continuous increase in the amount of time and money authorized for medical care.

Due to lack of influence in the formative stage, of workers for whom the law was designed, and of physicians on whom so much of its operation depends, compensation and medical benefits were ridiculously low. In the early stage of compensation, 22 states limited medical care to a period of 30 days or less and 24 states permitted no more than $100 to be expended for this service. Five of these gave no medical care whatever or only a funeral allowance to living dependents.

The niggardly limits upon medical aid so prevalent in American compensation acts are in keeping with inadequate benefits to the injured employee. When the price of a hand is set at only $2,000 there is little incentive for the employment of the best that surgery has to offer. But if the compensation for the loss of a hand were a life pension at one-half the individual's regular wages, neither employer nor insurance carriers would stint their efforts to save the industrial use of the threatened member. Given an appropriate scale of indemnity for death and permanent disability, no objection will anywhere be raised to unlimited medical benefits. For inadequate death and disability benefits there is at least the excuse of low cost to employers; but for insufficient medical, surgical and hospital benefits the pretext fails for the cost of unlimited therapeutic relief is, in per cent of payroll, a mere bagatelle. Yet, it is in their medical provisions that most American compensation laws are most absurdly deficient.

Belated recognition of the fact that the greatest boon that can be conferred on the worker is not to hand him a meager cash stipend while he is disabled, but to restore him as quickly and as fully as possible to a condition of health and productive employment, has led to rapid extension of the limits of medical care. In some states at the present time practically unlimited medical service is rendered.

Much of the real opposition to the liberalization of the compensation laws comes from the private insurance companies since it cuts into their profits.

The question of the costs of medical care in compensation is of vital interest to all those concerned. It has been shown that in the compensation business handled by stock companies each premium dollar is divided about as follows: the company receives 42 cents, the injured worker receives 38 cents in cash, and 20 cents goes for medical care. This 20 cents goes for hospital, drug and other expenses in addition to the physicians' fees.

Within recent years even employers and insurance companies have begun to look on medical relief in quite a different manner than they did in the beginning. The steady increase in compensation benefits, making medical neglect far more expensive, may have been one of the influences responsible for this change in outlook. At any rate there is now a decided inclination to favor thorough and competent medical care, although the efforts to beat down payments to

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, March 22, 1936.

physicians, surgeons and hospitals frequently defeat the objective.

Gradually a far more fundamental conception of the place of medical care in compensation has begun to gain public recognition and to find expression in legislative and administrative activities. When all the functions at the various stages of compensation are examined, it becomes evident that such care is by all odds the most important feature of the whole compensation situation, thus furnishing another illustration of the stone that was rejected becoming the cornerstone of the whole vast structure.

Recent careful analyses have revealed that accidents, even in modern industry, are still largely personal and individual and arise out of the physical and mental weaknesses and defects of the human factor in industry.

In order to perform his work safely the employee of a modern mill, mine or railway should think consistently in those mechanical terms in which the industrial process runs. He should respond automatically to the most varied mechanical emergencies and should be as insensible to fatigue and as invariable in behavior as the machines he operates. However, human nature, inherited from uncounted generations that knew not the machine, does not possess these attributes in anything like the requisite degree. The common man is neither an automaton nor an animated slide rule. His movements do, it is true, tend to fall into a natural rhythm, but the beat is both less rapid and more irregular than the motions of the machines, with the consequence that he fails to remove his hand before the blow falls. It requires an appreciable time for the red light or the warning gong to penetrate his consciousness, and his response is apt to be tardy or in the wrong direction. Fatigue, also, overcomes him, slowing his movements, lengthening his reaction time and diminishing his muscular accuracy, thereby greatly increasing his liability to accident.

It has been demonstrated that the failures of accident prevention programs have been due in no small part to focusing attention on mechanical, financial and disciplinary measures to the neglect of medical control of the physical and mental selection of the individual employee. It is believed that the part which human beings play in accidents will be more emphasized in the future. Physical and mental defects render certain workers peculiarly susceptible to accidents. Women rated as third class by physical examination show about nine times the accident rate that women rated as first class, in industrial occupations. Men rated as third class show nearly double the accident rate of those rated as second class.

Accident prevention under workmen's compensation seems to be evolving toward a situation where, without any reduction in the legal, mechanical and supervisory efforts to secure safety through mass action it is clear that there is an equally large field of individual personal activity where more fruitful results may be expected. The latter calls for close, continuous sympathetic knowledge of the individual. It involves a thorough physical examination for diagnosis and treatment as well as for employment purposes. This examination, it would seem, might best be performed by the employee's family physician, who would naturally give the necessary treatment. This would incidentally be far more economical than the many repeated examinations given by the physician of each plant where employment is sought.

When an accident takes place, the first person in the compensation system to come in contact with the victim is the physician. The character of the treatment that he gives and the response of the patient to that treatment, often largely determined by his confidence in the skill of the practitioner, are the decisive factors in all succeeding steps in compensation. If the injury is slight and is properly treated this is the first and the last step.

Schedules of compensation follow certain basic classifications. These schedules in most instances, unfortunately, have been drawn up by laymen, without professional advice, for, in the formative stages of compensation, medical cooperation was deemed unnecessary. In the majority of the states there is no medical representation on compensation commissions. The result would be ludicrous if it were not the basis on which dismembered human beings are compensated. Fingers, hands, feet and limbs are described and located in ways that no anatomist would recognize and so their loss is a wholly different injury in one state from what it is in another. In some states the hand ends at the wrist—in others it extends to the elbow. In a like manner the foot varies from the ankle to the knee.

On this foundation of an anatomy, which he

never learned in any medical school, is the physician forced to form his judgment of the injury suffered. His work is rendered more difficult by legal definitions of accident and disease that are at variance with scientific accuracy. Courts have held that if the "expert" knowledge of compensation commissions is at variance with established medical facts that the commissions are permitted to substitute their "expert" knowledge for established medical facts. Lay commissions have in many instances ruled themselves superior judges of medical facts to those who have spent years in medical training and medical practice. Thus we have the creation of symptoms of disease by court decisions and by administrative rulings which at the same time confer superior medical knowledge on lay commissioners without subjecting them to the necessity of earning a diploma or passing an examination.

It is regrettable that Florida's newly enacted Compensation Law does not provide for a medical member on the Industrial Commission which administers this law. This Industrial Commission is composed of three members, two of whom shall be selected by the Governor from his Cabinet and the other shall be appointed by the Governor for a term of four years. It is believed that the interests of all concerned would be protected and benefited by the addition to this Industrial Commission of a medical member. And, one is constrained to add, that this physician should not be selected in the interest of political expediency but should be named from a group carefully selected by the Florida Medical Association and submitted to the Governor. Should the group submitted not contain a name acceptable to His Excellency further names could be provided of qualified men.

In order to insure unprejudiced and sympathetic care, it is believed that absolutely free choice of physician or surgeon should be permitted the injured worker. Any arrangement which interferes with the time-honored patient-physician relationship materially detracts from the patient's confidence.

There is much to criticize relative to contract medical practice under Compensation. While it may be, and probably is, true that industrial surgery calls for some specialization it does not follow that getting a job with an industrial establishment or insurance carrier is a test of competence as a surgeon. Experience has shown that it is far more often a test of ability to meet certain economic and financial qualifications. The applicant is apt to be judged far more according to the salary he will accept, his ability to reduce labor turnover and his willingness to provide the sort of testimony that will keep down compensation payments, than by his educational background and professional attainments.

After he is hired, if his relation to his patients is forcibly determined by their economic position as employees, and if his ability to hold his position is determined in any degree by his success in keeping down the costs of compensation and reducing lost time, then to just that extent his professional actions are rendered an imperfect instrument for the production of good medical service. He must bend his scientific judgments to his economic interests as a very condition of survival, and he will be more strenuous and sincere in so doing the more he becomes unconscious of these influences.

There should be no solicitation or compulsion exercised on patients to compel them to enter into any scheme of medical care. Any deviation from this rule means that medical qualifications and consequent medical care are made subject to financial considerations.

All expenditures for medical care should go to those who give that care. There is no excuse for the presence of the profit taking promoter, organizer or entrepreneur between the physician, surgeon, nurse, hospital or other agent giving such care and the patient who receives it. Every attempt to introduce such a third party has been proved wasteful and harmful.

There should be medical representation in all compensation institutions proportionate to the medical interests involved. Questions of a purely medical nature should be passed upon by those who have met the standards set up by law to determine medical qualifications and who alone have been pronounced capable of passing on such questions.

There should be greater consideration for the human side of accident prevention programs and the active participation of physicians in such work.

(In preparing this address, liberal use has been made of information secured from publications issued by the Bureau of Medical Economics of the American Medical Association, R. G. Leland, M.D., Director).

HEALTH INSURANCE*

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In the days when the doctor traveled in a buggy and carried his drugs with him in a satchel, the expense of medical practice was not great. In those days, the doctor made most of his diagnoses from what the patient told him and from such simple examinations as he could make with his five senses. Nowadays, he uses all sorts of intricate apparatus for determining definitely the condition and ability to function of various organs in the human body. Today, by use of the x-rays, the doctor can actually see the outlines of almost every internal organ. No longer is it necessary for him to guess at the changes that have taken place in the blood. They can be measured by chemical, physical, and microscopic tests in the laboratory.

Few achievements of the modern, scientific age are more striking than the conquest of once widespread diseases in the progress of medical discovery. A host of diseases, like smallpox, yellow fever, malaria, and typhoid fever, which were once among the largest causes of sickness and death, have been abolished or reduced to a fraction of their former importance. In many others improved methods of treatment have shortened the period of recovery.

Around 1890, medicine was practiced only by the doctors with the aid of a few nurses. Today, in addition to the one hundred fifty-five thousand doctors in the United States, there are about one million, two hundred fifty thousand other people who spend their full time in taking care of the sick. These include nurses, dietitions, technicians, anesthetists, orderlies, and innumerable other special employees. Whereas, we formerly had less than one thousand hospitals in the United States, we now have about seven thousand hospitals. Overhead expense in medical practice has become tremendous and the medical bill has proportionately increased. In an earlier day, when a child was sick, the family usually took care of him at home. Most of the obstetric work was done in the home. Rarely was there any need for a hospital bill. Nowadays, practically all surgery and a great deal of medical care, in serious diseases, is carried out in the hospital. A part of the reason for this is the changing character of our civilization.

Modern medicine, therefore, costs more than medicine used to cost, but it is worth a great deal more. Through the advancement of modern scientific medicine, the expectancy of life, at birth, has moved up from thirty-three years to almost sixty years. Vast numbers of people live longer than people used to.

Investigators have found that the biggest difficulty, today, is the question of distribution. Not every one can afford large hospital bills or large medical bills. Sickness insurance is proposed, as a method of distributing the economic burden of sickness. People have not learned to save against the cost of medical bills, as they have saved against the cost of death. Life insurance is one way in which people save against the cost of death. Sickness insurance is a way of saving against the cost of sickness. It has been the hope of many economists and social workers that some means could be found to cause people, whether sick or well, to put a certain sum of money away each week, with the hope that they might have money available for paying the costs of severe sickness when it came upon them.

By the elimination of much serious illness, medicine has wiped out the fear of disease and it is, therefore, exceedingly difficult to make people save against disease. Death, they know, is certain; but, on disease, many of them are willing to gamble.

There are many foreign countries with systems of sickness insurance controlled by the state.

In brief, these systems provide that workers who receive less than a certain sum of money annually, shall have set aside from their wages a certain amount, the employer and state contributing a certain amount. But this type of health insurance leaves almost untouched the entire problem of care for the indigent sick and in no country has it perceptibly decreased expenditures for this purpose.

It is estimated that ninety per cent of the conditions for which most patients consult doctors can be diagnosed and treated by a good general practitioner, with only the amount of equipment he can carry in a handbag. Most people do not worry about paying for that kind of sickness. In this country, the bills that disturb them are those for major illnesses, such as pneumonia, and operations, as in cases of appendicitis. Nevertheless, in Great Britain, the sickness insurance system does not provide for these major illnesses

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, March 29, 1936.

but only for general medical service. Under the British system, when a man has to go into the hospital for an operation and is unable to pay, he goes into a charity hospital and is treated there by doctors who work without payment as they always have in the past. It has been a tradition of medicine that it always gives its services to the poor without question. Every year, the doctors of this country give many millions of dollars worth of service to the poor, getting in return for it, only the experience and such prestige as comes from having one's name on the staff of a great charity hospital.

No perfect system of sickness insurance has been worked out, as yet, in any nation. Even those most interested in insurance systems freely admit that none of the systems in use abroad would do for the American people. One of the reasons is the fact that Americans like to choose their own doctors. After all, the relationship between doctor and patient is one of the most intimate of human relationships. In some ways, it is even more intimate than the relationship a man has with his family.

Since insurance administration is controlled by cash considerations, quantity, rather than quality, of medical service, is stressed.

The essentials of a good diagnosis are time, patience, careful attention to details, and sympathetic relations between a skilled practitioner and a cooperating patient. Insurance compels haste and tends to create antagonism between patient and physician.

Insurance almost inevitably leads to over medication. Insurance seeks to check the steadily rising cost of drugs by the application of cash standards through restrictions on prescribing. Since sick individuals and scientific medical service do not fit these standards, treatment is hampered while the evil of unnecessary medication remains.

American doctors are proud of the kind of service that they have been giving to the American people. They can point to the fact that our sickness rates and death rates are about as low as, if not lower than, those of most of the large countries of the world. They can point to the fact that an investigation recently made by the Bureau of Economics of the American Medical Association revealed the fact that there are few, if any, people in the United States really suffering from a lack of medical care.

One reason why American doctors are somewhat opposed to similar systems of sickness insurance is the fact that the quality of medical care rendered is far below the average quality of care usually given in this country. In most of these systems, a doctor gets a list of about fifteen hundred persons to look after, when they are sick, and gets so much a person each year. In addition, he carries on his private practice. Now doctors are only human! By the very nature of the circumstances, there is a tendency to give less attention to those who come under the insurance system than to those who are directly responsible to the doctor for payment. For this reason, it is frequently found that even patients who are on sickness insurance lists will go to an outside doctor and pay his fee when they think anything serious is wrong with them.

This type of insurance has caused patients to come to their doctors repeatedly for minor illnesses in order that they might get their insurance. Prepayment for medical care, especially over a long period, creates a desire to "get something back" in the form of such care. This desire to "get something back" has a tendency to create the sickness that is the condition of obtaining the coveted service.

Does health insurance reduce the cost of medical care? There is really no evidence that it does. One thing it does is to add a tremendous burden of administrators who are in charge of keeping track of the cash and paying it out.

The biggest protests that have come from doctors in countries where these systems are in effect, are those having to do with the official red tape. When the doctor finally gets through with his work, he sometimes has to sit down for hours to fill out the red, the yellow, the blue, and the green blanks that are required, instead of spending his time and using his brains for the special purpose for which he is educated. In Germany, there are more administrators, stenographers, and clerks in the sickness insurance system than there are doctors.

Organized medicine in the United States has been responsible for the origin of public health departments, and the constantly rising standards of medical education and hospital practice. While every other occupation avows its mission to be the improvement of the economic conditions of its members, the medical profession has always insisted that its main mission is to protect the welfare of the individual and of the public. Individual physicians are human beings

and with all the weaknesses of human beings. But the organized profession has always maintained that the quality of medical service, the safeguarding of the public health, and the destruction of disease should be first. It is from this point of view, and with a record of more than a thousand years of adherence to these principles, that organized medicine approaches the question of insurance.

In no country has the organized medical profession declared itself against the principle of insurance as a method of payment for medical service.

Medical associations in the United States are interested in the operation of insurance systems, in all other countries, not so much from the economic effect on physicians or patients (although this phase has not been neglected) but chiefly with regard to the character of the medical service given, its effect on the general health of the insured, and its influence on the standards of medical practice.

Reports indicate that, in spite of the amount of medical care paid for, at almost nominal rates by the FERA, by far the larger portion of the care actually received by the unemployed, and many others not eligible to FERA benefits, during the past year was given without charge by physicians. Certainly, if there is any section of the people that has not been indifferent to the problem of medical care for indigents it has been the organized medical profession of the United States. State and county medical societies throughout the entire country are endeavoring to find the best method of giving good medical care to those unable to pay for it, and the fundamental necessity of maintaining the conditions on which good medical service depends has been kept uppermost. Experiments show that many of the methods of furnishing good medical service by some of the proposed systems destroy the fundamental conditions of good service. For that reason, organized medicine has opposed, or sharply criticised, the wholesale plans made by social workers, employers and laymen, very few of whom have proved their devotion, to those in whose interest they claim to act, by any such economic sacrifice as has been made by members of the medical profession.

The doctors have recognized the necessity of giving to all the sick the right kind of medical care. They have always done it in the past, and there is no reason to believe that they will fail to do their duty and to maintain their ideals in the future.

CONTRACT PRACTICE*

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Contract practice, as a phase of medicine, is not new. It began as an essential feature of many pioneering projects, in mining, railroad construction and lumbering. It is now assuming new forms, becoming highly competitive, using unethical methods and involving a large number of physicians.

Ever since men achieved the first states of civilization there has been nothing they would refuse to do to attain health when they have been sick. As Oliver Wendell Holmes says, in his Medical Essays, *"They have been willing to be half-drowned, pierced with needles, branded with hot irons, to have leeches suck their blood, to swallow vile tasting concoctions* and to pay for all of this in the hope of curing disease and of regaining health." Now, it may be added, many are willing to bargain with the lowest bidder, on a contract basis, for an incompetent and inadequate medical service, and that for only a part of the family, because some *solicitor* tells them that they will receive the best medical care, at a ridiculously *small sum!*

About the middle of the last century two types of medical practice were developed, which were destined to be forerunners of a dangerous complicated commercial medical system. One of these types was the Mutual Benevolent Hospital Association, philanthropic in character, having liberal endowments, extensive hospital properties and a hospital staff of highgrade reputable physicians, all organized and maintained for the membership only. The other type was the medical service developed by the railroad, mining and lumbering companies for their workmen employed in places in advance of or apart from communities with medical facilities. The Mutual Benevolent Hospital Associations were organized to provide for their membership the best obtainable medical services at the most reasonable cost. The railroad, mining and lumbering companies were moved by two factors to provide medical care for their employees:

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, April 12, 1936.

First: Because medical service could not be secured otherwise.

Second: To avoid or to minimize the liability that might accrue or arise from neglect of medical care and to reduce the loss to the companies in working hours thus affecting production because of accident or illness.

The precedent of such plans, developed by the exigency of the situation, the enactment of State Workmen's Compensation Laws and the popular lay revolt against the cost of medical care, are now used as ample justification for the present system of contract practice. All the contract plans now operating are essentially forms of sickness insurance.

The types of contract practice vary, according to the organization providing the medical service and the form of contract used. There exists definite conditions under which contract practice is both legitimate and ethical, but these instances cannot be used in defense of unethical, highly competitive and economically unsound methods, used by unscrupulous individuals or groups, to further commercial or professional avarice. The type of contract and service rendered will depend largely on the integrity of those who devise and operate the system. The contract coverage may be one of three types: first: for employment connected injuries; second: for employment connected injuries and illness; third: for injuries or illness which are either employment connected or which may have no relation to employment.

The types of organizations, or groups, engaged in contract practice are many. To mention a few: large corporations, such as railroads, mining companies, oil companies, logging and lumber companies, canneries, ship-building and allied shipping companies and other manufacturing companies; next, mutual benefit associations, medical groups and clinics, individual physicians, county medical societies, hospitals, newspapers, cooperative groups, industrial associations comprising mutual benefit associations, trade unions, and lodges.

Many large corporations own and operate their hospitals. Physicians are employed by contact, and the employees are cared for on a monthly payroll-deduction basis. Some mutual benefit associations also own hospitals and employ physicians in a manner similar to the large corporations, but all of this medical service is maintained at the low monthly pay-rate for members only. Because of the low amount of income from members, on such low monthly rates, these associations would soon be obliged to discontinue their service were it not for generous endowments left by members and the profit accruing from hospital care of the public at regular rates.

Hospital associations are misnomers. In most instances they are merely the business offices of groups having medical contracts for sale. These associations usually have a few staff physicians on salary, but most of the physicians who care for the contract cases are paid on a piece-work basis. Not infrequently these physicians have difficulty in securing payment for services rendered, and then at the amount allowed by some lay business manager, whose business it is to deal with the profession, as well as with employers and employees.

It is not uncommon for these czaristic adjusters to dictate to physicians the extent to which their service shall go in an individual case.

Since some of the best medical groups are doing contract practice naturally the type of service they render is superior to that given by many of the hospital associations. Yet, while engaged in contract medicine, many of these groups complain they are not satisfied with this type of practice.

Much of the anxiety on the part of the profession over contract practice has grown out of the methods used by individual physicians in the field. For instance, one organization of this type is owned by one physician who has a large number of associates operating in many communities. In one particular instance, the owner and operator of the contract plan views medical practice with an extremely cold-blooded business attitude, appearing to have no interest in any form of medical charity and thinks very poorly of organized medicine, his respect for medical ethics being apparently negligible, this physician thoroughly believing that his system is the only correct one and that all physicians *must ultimately solicit business!*

In an effort to meet the growing competition of contract individuals and medical groups, a number of county medical societies have devised plans to take contracts as organized bodies. These societies were motivated by the desire to furnish the low income groups a medical service at a small cost, to render the same quality of service that is given their regular fee patients,

to offer free choice of physician, and to eliminate unfair competition.

Hospitals have entered the field of contract practice by assuming the business management of contract solicitation. This form of contract practice is no less devoid of the unethical and undesirable features than the types already mentioned. Throughout the contract proponent groups there exists a definite fear lest the organized medical societies object or interfere with contract operations. Likewise, there is a craftiness in business dealing and a circumvention of accepted ethics in many contract plans.

As long as contract practice remained in the field of practical necessity it created little or no alarm, but as the exigencies of pioneer projects passed, the emergency methods of medical care were not discarded but were retained to become the basis of new schemes to compete with regularly established medical practice.

Workmen's compensation laws have been passed and funds made available with which to pay for medical care to injured employees. These funds which assure the payment of fees for hundreds of thousands of potential patients became the envy of conniving contract cliques, so that at this point a method was introduced in contract practice similar to high pressure selling in the business world.

Not all patients having contract privilege understand the coverage or exemption of the contract. Under the pressure of increasing competition the agent or solicitor may have misrepresented or failed to make clear the coverage when making the sale. The patient suffers from these methods when he finds that conditions for which he presents himself for treatment are not included in the contract, and, therefore, must pay for treatment or seek a private physician.

Almost all types of contracts, except those used by the cooperating groups and newspapers, cover the *individual* workers only and fail to include members of his family. Whatever the advantages claimed for strictly individual contract practice these benefits cannot accrue to women unless they are employees, and in no case to the children.

In only one instance that has come to our notice is any attention given to preventive medicine.

It is claimed that some contract plans offer the individual covered a free choice of physician. It is possible that there are such plans contemplated, but as far as is known at present, there is no plan which included all physicians in a community. The use of the term "free choice of physician" is, under these conditions, misleading, if not fraudulent misrepresentation.

Contract practice has created in the minds of both the public and the individual a false impression of physicians and medical service. Not only financial or business, but also the intimate professional relationships between patient and physician are changed. This relationship which for centuries has been peculiarly close and personal is now robbed of that intimacy and friendliness of understanding which characterized medical practice.

Medical and surgical treatment are indefinite scientific services, measured in nature and amount according to the demands of the individual case. Medical service, therefore, is not comparable to commodities sold by units or measures of weight, which are always constant. The bidding and underbidding, bargaining and adjusting practiced in securing contracts places medical service on a level with ordinary merchandise. As there is such a great variety of contracts each case may be judged on its own merits after all the facts pertaining thereto are known. There are certain points, however, that may be formulated, which, when present, one or more of them, definitely determine a contract to be unfair or unethical. These may be stated as follows: (1) When compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community. (2) When the compensation is so low as to make it impossible for competent service to be rendered. (3) When there is underbidding by physicians in order to secure the contract. (4) When a reasonable degree of free choice of physician is denied those cared for in a community in which other competent physicians are readily available. (5) When there is solicitation of patients directly or indirectly.

The organized profession has no desire to obstruct reasonable and honest efforts to provide the best medical care possible to persons receiving low incomes. It is essential that the *welfare of the individual be kept always foremost.* It is believed that the success of any system must be predicated on separation of the medical service rendered by the profession and the collection and administration of funds that are to pay for the service. Furthermore, the practice of requiring

physicians to certify to cash benefits must be modified or eliminated entirely. The physician's chief interest and duty should be in the care appropriate to returning his patient to normal health as soon as possible. His is a service benefit to the patient and he should not be made "the goat" in passing judgment by certificates or otherwise on cash benefits in which his patient may share.

While many phases of contract practice deserve more detailed description and comment than is possible in this brief discussion, it may be stated that contract practice—

1. Took its origin largely from necessity;
2. Has been legalized, in certain places by state statute;
3. Under certain conditions and in some forms is both ethical and legitimate;
4. In general, has become highly commercialized and competitive;
5. Is largely limited to the pay roll class;
6. Does not, in most cases, extend its provisions to women and children;
7. Concerns itself, almost without exception, to curative medicine and does not include preventive measures;
8. Shows no interest in public or individual welfare;
9. Furnishes medical care which is often inferior in character;
10. In many instances is characterized by underbidding, subletting, misrepresentation and racketeering;
11. Is economically unsound in many of its present forms.
12. Is essentially sickness insurance usually not supervised or regulated.
13. Is often used by the operators thereof to influence legislation in favor of extension of the plan;
14. In many of its present forms, lowers the confidence of both the individual and the public in the medical profession;
15. Has some features that deserve refinement and extension and others that are unethical and dangerous and should be abolished.

(The material here presented was assembled from information contained in pamphlet reprinted from the Journal of American Medical Association, a copyrighted publication, and is fully credited to R. G. Leland, M.D., Director, Bureau of Medical Economics, American Medical Assn., Chicago).

PLANS FOR PAYMENT OF MEDICAL CARE*

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From the earliest records of history, there is evidence of institutions that might be called hospitals. Hospitals of the early centuries of the Christian era were established for various purposes; the housing and relief of orphaned children, the aged, the poor, the infirm, the lame and the blind, and for lepers outside the towns. These were charitable, relief, and service institutions and no doubt contributed much to the comfort of the unfortunates who applied for succor. It is not definitely known, in each instance, to what degree medical care and nursing constituted the functions of these hospitals, but it should be clear that the expansion of this phase of hospital service was directly dependent on the progress of general science and medicine.

The hospital in its modern sense was but slowly created. Certain of the early types of service seem to have persisted, and these are now found in institutions organized for special purposes, such as children's hospitals, city and county hospitals for the poor, communicable disease hospitals, and maternity hospitals. It seems safe to infer, therefore, that hospitals have followed the developments in medical knowledge and have been organized to provide service in both the general and the special fields of medical practice.

Since hospitals have furnished a service which, in certain instances, has contributed to the facility of medical practice and to the safety and comfort of the patient, the ideals, customs, and ethical principles governing hospital practice have gradually been brought closely to parallel the principles of ethics of the medical profession. If the medical profession and hospitals are to serve the public on an equally high ethical and professional plane, the ideals and objectives of the two institutions must be identical.

There seems to have arisen some confusion relative to the capital investment of the medical profession as compared with the capital investment of hospitals. Although each physician must expend, for his preparation and physical equipment, a certain amount of cash which may be considered a portion of his capital investment,

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, April 19, 1936.

before he may practice medicine, the larger and ever-increasing chief capital investment in medicine is represented by the constantly accumulating body of knowledge, a capital fund which is not the property of any individual or group of physicians and the benefits from which the profession has always freely made available to the public.

This may be compared with and contrasted to the constantly increasing value of hospital, clinic, laboratory, and allied properties and equipment. This capital with some few exceptions, is not held exclusively as an individual or group asset; in the majority of instances it constitutes, broadly speaking, a trust investment for the good of the community, in reality a social possession. Even in the case of privately owned institutions there is a definitely implied social interest.

The real medical capital, first mentioned, consisting of accumulated knowledge, is stored in the minds, ideals, and traditions and in the publications of the medical profession, and is shared freely with the public through Universities, journals, discussions, the public press, radio, and the individual consultations. The capital cannot be monopolized for profit. It does not fit into the capital concept of industrial economies, yet it is the greatest asset of the profession. Without it, all physical capital would be worthless.

The capital investment in hospitals is variously estimated at approximately three billion dollars, most of which is organized or incorporated on a non-profit basis, although about 10% of this amount is to be found in hospitals organized for profit. This predominance of non-profit bearing hospital capital, together with the support of these institutions by philanthropy and public good will, is evidence of the general acceptance of the social interest and possession concept of hospital properties and service. The entire investment in hospital properties, including those hospitals for profit, has been made for the benefit of the public. But the public can reap its benefits from these investments only to the extent that the physical capital of hospitals serves and assists the knowledge and experience possessed by the medical profession.

This fact of dominance of the "professional knowledge capital" is of primary importance in the development of any program of furnishing medical service, including hospital care. The physical capital must remain the instrument wielded by the personal skill and knowledge.

During the past decade, the physical capital of hospitals has been enormously increased. This expansion may have been in keeping with the general trend to pre-economic depression period. It is difficult to show that this expansion always follows a well-established need. It is also difficult to reconcile some of the cost of inordinately expensive construction and equipment with the requirements of good medical care. Nevertheless, the capital has been invested, interest becomes payable regularly, building bonds must be retired, and maintenance is necessary. Because of shrunken incomes, there seems to be not only a diminished use of hospital service, but, where hospital care is necessary, there is also increased difficulty in making collections. This income of philanthropists and supporting foundation funds have likewise contracted, thus somewhat effecting certain hospitals and institutions.

Sensing the financial pressure with which hospitals are faced and utilizing the popular discussion about the costs of medical care, certain commercial interests have recently developed mass production schemes for hospital care, seeking to create a larger market to provide more funds with which to meet the hospital overhead costs. It is significant that this attempt to capture the professions by the use of mass production methods in the marketing of medical and hospital care should appear just when industry and business are endeavoring to incorporate into their methods some of the characteristics of the professions. At the present moment, efforts to "professionalize" business are being directed by trade associations, legislation, and a host of semi-public bodies and interested individuals in an effort to restrain some of the excesses in business.

With a few exceptions, group hospitalization schemes are now being made by commercial organizations seeking contracts for from one to five years with hospital for hospitalization membership campaigns. The contract with the hospital may or may not guarantee a definite number of members, but it always states the commission on which the organization agrees to undertake sales work. These commissions vary from 21% to 75% of the amounts paid by the members. Members are usually secured in groups, although some organizations solicit individuals. The cost to members varies from $6.00 to $24.00 annually.

It is claimed by some of the promoters that

a free choice of both physician and hospital is granted the members, but obviously this is a misrepresentation whenever all physicians and hospitals in a community are not included.

Monthly contract payments by members are usually made by payroll deductions whenever members are secured in groups. Members are usually entitled to 21 days of hospital care during any 12 months period. Patients requiring more than that are entitled to from 25% to 50% reduction from regular hospital rates.

There is a wide difference in the methods of handling funds. One scheme provides that the hospital giving the service may draw on the promoting organization for the full amount due; the balance remaining at the end of the year to be prorated among the participating hospitals. Other schemes provide that the monthly membership premiums shall be paid directly to the hospitals; none of the schemes provide for an adequate safeguard of funds.

Although promoters have placed in their contracts certain limitations on service to which members are entitled, they have likewise included, in several instances, as a part of the hospital care, a number of distinctly medical services which must be given by the physicians without pay.

The experience in the field of hospital insurance is too limited to provide reliable data concerning the quality of service rendered.

To a large extent, such schemes are being installed as a result of desperation, in which hard-pressed hospitals are seeking any port in a storm.

The adoption of such a plan by a single hospital or group of hospitals in a locality, creates a division within the hospital field, and the medical profession. By creating an artificial monopoly through salesmanship and through compulsion by employers, "unfair competition" is exerted on those hospitals outside the scheme. This situation encourages the formation of rival groups and such undesirable forms of commercial competition as solicitation, under-bidding, and consequent deterioration of service. It also destroys freedom of choice of physician and hospitals for as large a section of the population as are induced to become members or certificate holders. All such plans tend to decrease the effectiveness of the most important form of professional control of standards and ethics, while at the same time, it increases the influence of lay commercial interests.

Even with all the safeguards of the British system, most of which are absent from American schemes, the question of control of hospital management by lay organizers of contributory schemes, is becoming troublesome. Does anyone believe that, once a promoting organization, perhaps of nation-wide scope has, through a system of contracts, gained control of a large share of the market for hospital service, that it will hesitate to use that power or influence to control hospital management?

Such plans tend to extend hospital care beyond its scope. Patients who would ordinarily be cared for by a family physician at home, will more often insist on going to the hospital where they feel they have already paid for care.

The employment of salesmen, especially on commission, which is a feature of most plans, introduces all the elements of commercial competition including some that are considered unfair, even in business. Such plans depend on securing contracts for future sales from a large section of the market for medical services and then using the monopoly so secured to fix the terms of such service. When this monopoly is further buttressed by group and employment compulsions, denying to the individual for some time in the future the right to select the form and source of his medical service, conditions are created closely analogous to those that have already been condemned in business by the Federal Trade Commission and the Courts. Such comparatively mild methods of insuring future patronage as is offered by "trading stamps" has been forbidden by law in many states.

The moment the sphere of commercial competition is permitted to invade the organization, direction and marketing of medical services, and especially if these functions are placed in profit seeking commercial hands, the whole history of medical practice has shown that deterioration in ethics and service inevitably follows. Rival schemes fight for survival by lowering payments for professional services, by more flamboyant advertising, and by giving inferior service.

Every new social arrangement tends to become a nucleus of much wider developments and to establish institutions, customs and vested interests having an influence far beyond the immediate intentions of the founders. This will almost certainly be true of hospital insurance. The first tendency, already developed in several schemes, is to extend the scope of the scheme

from hospitalization to general medical care. These schemes are practically always managed by profit-seeking promoters. If general medical care for the lower paid workers is to be placed on an insurance basis, it certainly should not be introduced incidentally through plans organized for other purposes and in ways hostile to the best interest of the patient and considered opinions of the organized profession.

The broad effect of all these plans is to shift the burden of hospital support from philanthropy and good will, to assessment of low paid workers. Those promoting such schemes are in it for the profit and can only increase the general cost of medical care. So, before entering into any scheme for hospital or health insurance, investigate the real merits of it. When you need hospital or medical care, you prefer being in a position to select what you think is the best, and not be forced to accept what is furnished you by some insurance company.

HEALTH INSURANCE IN ENGLAND*

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During the recent years of economic stress, interest has become widespread in providing adequate medical care for those unable to secure it for themselves. Men and women from every walk of life have united in a popular effort to provide medical attention for every person in the United States regardless of financial status. Politicians and lawmakers, sensing the will of the people, are interested in legislative measures looking to a solution of this great problem. Now that the public conscience is awake to the importance of establishing agencies for rendering adequate medical care to all, it is but natural that we inquire into the efforts that have been made to solve the problem in the other great English-speaking nation of the world. A large number of interested persons are already using as a basis for their thinking the *Public Health Insurance Act of England.*

This act was proposed in 1911 by Lloyd George because of the increasing need for helping citizens with limited income to secure medical care. It was sponsored in the beginning by the Labor Party, but soon all classes of British citizens recognized the need of such legislation and the following year the *Health Insurance Act* was adopted as part of a general program of legislation designated as *Social Insurance Legislation.* We are concerned only with the medical features of this act.

Our British friends have set up the "panel system", in which physicians who so desire have their names placed on a list or "panel" from which the eligible layman, having qualified to receive compulsory insurance, selects a physician to treat him in case of illness. To qualify, he must be an employee with an income not exceeding $1,250.00 a year. The premium for this insurance is paid from three sources; forty per cent by the employee from his wages, forty per cent by the employer, and twenty per cent by the state. From the fund so established the insured person may receive, in addition to medical care, other benefits consisting of a cash amount weekly for a limited time, a cash disability benefit for six months, and in case of childbirth and maternity, another cash payment. Tuberculous patients are sent to a sanitarium. This plan seems to suggest very happy progress toward a solution of the problem of medical care, but close scrutiny reveals its limitations.

In the first place, the patient receives only that treatment which can be rendered either in his home or in the doctor's office. There is no provision for laboratory studies, x-ray examinations, surgical or any other treatment which is available only in a hospital; nor is there any aid whatever given to help a patient obtain hospitalization. In the second place, only those workers with a definitely limited income are eligible for the insurance which this act makes possible. It has no provision for medical attention for the thousands who normally must be cared for by charities. It is, therefore, obvious at the outset that the *Health Insurance Act of England* is designed to solve only the one phase of the great problem of medical care which pertains to workers receiving up to $1,250.00 annually.

Despite minor changes this law stands today, with two notable exceptions, just about as originally designed by the author. Owing to the objections of insurance companies, the provision for death benefits was removed from the bill. Also, at the insistence of the medical profession certain methods of operation were authorized in order to further the spirit of fine cooperation which, through the centuries, has developed be-

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, April 26, 1936.

tween patient and physician. The latter revision has enabled organized medicine in the British Isles to preserve this relationship in a more wholesome manner than has been possible in other countries which have adopted similar legislation without this provision. It offers one of the chief reasons for the statement, frequently heard, that medical legislation in England approaches the ideal for it grants to every physician the right to have his name listed on the panel, it permits no interruption of the relationship, once it is established, between physician and patient and it provides proper representation of the profession in the administration of the plan.

Under this panel system, now in operation for practically a quarter of a century, we find that there are insured today between fifteen and seventeen million persons in the British Isles. To care for them in the manner described, forty-two per cent of the physicians have volunteered their services, for which they are compensated from the insurance fund that has been intrusted to approved societies, insurance companies and similar bodies. It is estimated that the income these physicians receive from this type of work averages $1,000.00 a year. They of course engage in other practice.

To some it appears then that these physicians are benefited, at least financially. As for the nation, it appears that great benefit should accrue to the individual, to industry and to public health from the liberal supervision in the home and in the physician's office of the health of one-third of the population, even though the more specialized investigation and treatment, obtainable only in a hospital and frequently highly important, are not available under the plan. Surprisingly enough, the records show the contrary. A quotation from the *Saturday Evening Post* of January 25, 1936, (page 22) follows: "According to a study of conditions in England, . . . the time lost through sickness by insured workmen averaged twelve and one-half days per man yearly, an aggregate of twelve months' work for 558,000 persons. Before compulsory insurance went into effect, the loss was only nine days; the increase under the insurance scheme being more than 38 per cent. . . . The comparison with American figures is striking, for the average loss of time by our workmen is only about six and one-half days a year, and the figures have been stationary at that level for a quarter of a century." In the light of this information, lack of compulsory health insurance in the United States is apparently no great disadvantage.

It is generally agreed by those who favor the act and also by those who do not, that several definite benefits have resulted from it. A large number of persons now receive better medical attention than formerly. This service is both greater in amount and superior in quality to the attention the individual members of the various clubs received prior to 1912. Illness comes under the observation of trained physicians at an earlier period than formerly, thus enabling the profession to be more active in preventive medicine. Clinical records, now more complete, are of greater value for health data. Members of the medical profession are becoming more cooperative, and the profession as a whole is appreciating more and more its collective responsibility to the community in respect to health matters.

However advantageous the *Public Health Insurance Act* may be in England, certain differences between that country and our own call into question the advisability of similar legislation for us. In the first place, England is only eight per cent agricultural whereas our proportion is nearer fifty per cent. Also, in 1912 when the act was adopted, conditions there were quite different from those in the United States at the present time. The practice of medicine was very largely in the hands of private groups, and contract practice was quite the rule. In addition, the English hospital system was then and is now quite different from ours. To the voluntary hospitals, designed for the indigent sick and supported almost wholly by voluntary contributions, only the very poor are admitted. Persons of ample means are treated in private hospitals or nursing homes, but for persons of moderate or limited means there is no general provision. In our own country no such system exists for there is hardly a community which does not have adequate hospital facilities available for persons of every financial status. Furthermore, in 1911 when this act was proposed, an appreciable percentage of the population, consisting of some eight or ten million workmen, was not wholly without employment.

In a nation founded upon principles of freedom of thought and speech, unanimity of opinion on so complicated a question as medical care for all would be nothing short of miraculous. Nevertheless, on this subject the medical pro-

fession of the United States has convictions upon which there is widespread agreement among its members. It is convinced that the relationship between physician and patient should be a personal matter, unhampered by administrative interference; that the patient should select his own physician rather than have him appointed by some layman or representative of the government, of a financial body, insurance company or society; and, also, that financial compensation for medical service may well be handled by a group which includes a sufficient number of physicians to insure that the patient receives attention from one whom he compensates in some degree by his own efforts. To maintain the correct financial relationship between physician and patient, it seems advisable to separate this form of compensation from all others, such as cash unemployment and death benefits.

In our country with its forty-nine political divisions exclusive of territories, it seems highly impractical to make regulations applicable to every governmental division. Instead, a localized handling of the problem by the political unit which is the county appears expedient. Certainly any plan suitable for adoption in this country should be more comprehensive than the English system, which is restricted to provision for that care only which can be given in the patient's home or the physician's office. The advantages of modern laboratory studies and hospital treatment, when needed, should be available to every American citizen.

The medical profession of a number of counties, notably Almeda and San Diego counties in California and Wayne County, which includes Detroit, in Michigan, is at present endeavoring to meet the problem by establishing a central sorting unit, such as a clinic, with an information bureau and a registry, which receives requests for medical care from patients, physicians or laymen. This intermediary then secures from the medical profession the attention which the patient needs. After proper investigation has been made into the financial responsibility of the individual served, the attending physician receives his compensation from the patient, his employer or others interested in him, in proportion as the funds are received from him or them for this purpose. The fees range from nothing to the average for the community. Thus the indigent and those of limited means receive proper attention and the persons who are able to pay are cared for as formerly. Quite properly, this plan is primarily controlled by physicians for they have always given freely of their services to the unfortunate and those of limited means and are preeminently qualified to understand and meet their medical needs.

The question of adequate medical care for those unable to secure it for themselves deserves thorough study. Certainly any hasty action would be ill-advised at this time. It might easily be a step that would lead us in the wrong direction and one that we might find difficult to retrace. As our problem can never be identical with that of another country, we wisely hesitate to model our program upon any foreign system. The ideal of proper medical care for every person in the nation is our goal. The medical profession is whole-heartedly in accord with this ideal and earnestly seeks its attainment upon the basis of efficiency, fairness and justice to all concerned.

HEALTH INSURANCE IN VARIOUS PARTS OF THE WORLD*

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With the gradual mechanization and industrialization of life in America new forms of medical practice have been introduced from time to time. Thus the established relationship between physician and patient has been gradually modified. We shall point out some of these new forms with criticism of same.

The insurance-against-sickness plan has been introduced in some instances by private insurance companies doing a general insurance business; in other instances by companies formed for the specific purpose of providing funds against operative and obstetrical procedures, as well as illnesses requiring hospitalization.

The charters of certain of these corporations indicate that it is proposed to offer complete medical care, including hospitalization, diagnostic care and treatment, and that it is proposed to sell drugs and medicine at cut rates made possible by large scale buying. It is noteworthy that these corporations are established for profit, to vend the services of physicians to the public. This is essentially the application of the methods of big business to medical practice.

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, May 3, 1936.

In spite of the fact that such plans have been formulated by expert insurance men cooperating with able physicians there are, nevertheless, serious objections to be raised.

The plan provides for no free choice of physician except that of the insurer when he decides to accept the services of the group. The medical care must be given by physicians belonging to the specially selected and organized groups or their assistants. The plan makes no clear provision regarding the number of assistants employed by any physician within the group or the methods of compensation. This opens the way to the defect existing in the original British law, now removed by amendments, by means of which the physician hired a number of cheaper assistants who did work for less than was paid in the insurance plan, the difference going to the physician at the head of the group.

Such a plan inevitably provides for the exclusion of most of the medical profession from its operation. Recent graduates could enter the profession only by becoming assistants to members of the group or by attempting to obtain a foothold in the greatly overcrowded and constantly diminishing field of private practice. The whole scheme rests on solicitation by salesmen at a profit to the managing corporation.

Perhaps the worst feature of the plan is the certainty that it will disrupt the medical profession in any community in which it is established. There is no doubt that while benefiting a minority of the profession, it will disorganize and impoverish the majority. Most independent physicians cannot hope for any considerable share of private practice in competition with the high pressure salesmen employed by the insurance companies.

Once there are a number of competing schemes in the field poorer grades of the population will be successively tapped by schemes offering cheaper and inferior service. The next step in such competition in every country has always been that the payment for medical service is cut with the further deterioration of the medical service and a decline in professional influence.

When one comes to the so-called hospital associations one finds for example, a type of contract known as the "full coverage contract." By virtue of this the association promises and agrees to bear the expense of medical and surgical services, including the services of specialists, hospital services, medicines and medical and surgical appliances, nursing, dental services, ambulance services, x-ray and clinical laboratory diagnoses, physical therapy and prophylaxis for employees of stated industries.

Such hospital associations are misnomers. They are not what their name implies, associations of hospitals, but merely business offices organized to secure and to hold contracts for medical and hospital service and to arrange with a limited number of physicians and hospitals to render that service.

It is characteristic of almost all these schemes that those for whom the benefits are designed are placed under compulsion to accept the services offered or pay for medical, dental or hospital care themselves. In short, persons covered by the contracts are not given free choice of physician.

The associations are, as a rule, incorporated for profit. Such a profit must be derived from vending the services of salaried physicians or of physicians who accept the low fees available under the contracts.

There is no reason why a third party should distribute medical services; particularly as such third party agencies are motivated largely by the profits that can be derived from the marketing of medical services.

It is asserted that such associations furnish only the highest type of medical care, but it is evident upon investigation that the best type of medical care is not furnished and that it could not be furnished by such a system for the prices paid.

Certain types of contract schemes would not be successful if contract physicians and organizations were obliged to wait until industry sought them out for their particular services.

A certain medical insurance society so regulates its business that the payment of the physician's fee depends on the disease from which the patient is suffering. Thus the fee becomes contingent upon the diagnosis, which not only opens the way to disputes as to the accuracy of the diagnosis itself but introduces a financial influence into the diagnosis itself.

In one instance a newspaper conceived the brilliant plan of including medical services with the daily newspaper. The advertisement stated that 200 leading surgeons and physicians were ready to give their services. The number dwindled to 23 when the list became final. Just

what medical authority picked these so-called leaders the advertising failed to state.

Adequate medical service cannot possibly be delivered for $1.35 a month as promised by the newspaper. In fact, it should be obvious that the rates quoted are utterly inadequate to provide any medical service except the barest first aid for minor afflictions. To provide complete medical services at such rates would mean swift bankruptcy for any honest and conscientious individual or group. Although the advertisements of this service lead the reader to believe that medical service is to be provided for all illnesses, nowhere is there a definite statement to that effect.

Fear, as usual, continues to be played up for purposes of advertisement. The advertising of a urinalysis service is of the scare type, and consists of grouping clippings of newspaper reports and deaths from heart disease of persons between 30 and 50 years of age. Furthermore, the advertising implies that the first step in guarding against the pictured horror of heart disease and other ailments is not to consult a physician and have a thorough examination, but to simply have four urinalyses yearly for which the charge of $12.00 is made. One of the published testimonials speaks of "the mind's ease of knowing what the test tube tells about heart and kidneys every three months."

The trained physician knows that a urinalysis alone does not justify any such "mind's ease" as has been conferred on the writer of this testimonial. It would be just as easy to write similar scare advertising with promise of similar "mind's ease," for a metabolism test, x-ray examination, blood pressure determination, or other standard parts of a genuine diagnostic examination as for a urinalysis. Moreover, if such commercial schemes as the one described prove profitable to their promoters we may expect to see all of these other tests that lend themselves to mass handling exploited in the same way. Such disintegration and individual exploitation for profit, of the many parts of what is of value only as a complete whole, cannot be helpful in assuring good medical care at reasonable cost.

Many hospitals followed industry in a wild inflation ending in 1929 and are now suffering the ills of industry in depression. Empty beds, rising deficits and, in many cases, approaching bankruptcy with consequent closure constitute the problem. British hospitals, confronted with somewhat similar conditions have found some measure of relief in their "contributory schemes." Such schemes, of course, would inevitably find their way to the United States and in many instances we find American hospital schemes modeled upon a somewhat similar basis. A survey of developments shows that the schemes have changed greatly and not always for the better, during their transatlantic trip.

Until within comparatively recent times hospital care in Great Britain was furnished almost entirely by so-called voluntary hospitals. Most of these were endowed teaching institutions staffed by medical men who received no salaries but who gave free service to the poor.

With the increase in the demand for hospital care the voluntary hospitals became overcrowded as well as underfinanced. Thus the hospital contributory schemes were established with the idea of securing increased support for the hospitals. The customary fee is 6 cents weekly or $3.00 a year. These contributions are collected largely from groups, such as employees of large establishments and trade unions. In spite of the fact that explicit warning is given to the contrary, these schemes have come to take on more of an insurance character and today the contributors undoubtedly look on their contributions as advance payment for hospital care.

These schemes increased the movement toward hospitalization in the British Isles until facilities of the hospitals began to be exhausted, whereupon the schemes assisted in financing extensions of the hospitals or in building convalescent homes.

As these schemes have grown, the demands on the staffs of the voluntary hospitals have become so great and the opportunities for private practice so restricted as to cause considerable discontent on the part of the physicians.

None of these schemes attempt to pay the full cost of hospitalization but all depend in part upon private charity or public funds. It is safe to say that no one connected with them would tolerate the suggestion of a private profit-taking company into any phase of the management.

While there is frequent reference to British experience by the promoters of American plans for hospital insurance, the dominant pattern in the country has been the industrial systems of medical care already so extensive and so largely peculiar to the United States. The principles of business rather than philanthropy have directed

the forms of organization and the methods of management. Actuarial calculations have been taken from insurance companies to transfer the entire burden to contributors and bring profits rather than partial support to the hospitals. The advocates urge that the contributors will not only pay for their own hospitalization but will relieve previous philanthropic givers from some of the burden of caring for free cases. The methods of business salesmanship, perhaps the least desirable of modern business, are utilized to a high degree.

The hospital insurance plan of Baylor University Hospital, Dallas, Texas, was one of the first in the United States. Similar plans were soon adopted by a number of other hospitals and the movement began to take on a wider scope. Two additional features soon entered the picture, namely, the organization of a general scheme embracing several hospitals and the introduction of professional, profit-seeking promoters.

The plans installed by promoters are all much on the same pattern as to rates and the provisions of hospitalization, although some recent schemes are showing a tendency to reduce contributions, which must result in deterioration of services or exploitation of the hospitals. The amount of commission charged for installing and operating the plan in the schemes studied varies from 21-75%. In some cases there is a system of "reserves" which would seem to offer opportunity for the diversion of considerable additional sums into the pockets of promoters.

The moment the sphere of commercial competition is permitted to invade the organization, direction and marketing of medical services, and especially if these functions are placed in profit-seeking commercial hands, the whole history of medical practice has shown that deterioration in ethics and service inevitably follows. Rival schemes fight for survival by lowering payments for professional services, by more flamboyant advertising and exaggerated promises and by giving inferior service.

In October, 1932, the Journal of the American Medical Association published a series of articles by the bureau of medical economics. Emphasis was placed upon certain dangers and abuses likely to be associated with attempts to apply the insurance principle to medical care. Among the dangers pointed out was that of the possibility of profit-making plans in this field easily degenerating into fraudulent rackets. The truth of this prophesy is illustrated by the findings of Assistant Attorney General Leslie G. Gillen. The San Francisco Examiner of April 30, 1932, quoted him as follows: "between 4,000-5,000 persons are making payments of from $1 to $5 a month into health and hospital organizations which are either suspended from business or do not exist as far as the State of California knows."

Thus, if the money collected and even worse than wasted, is to be counted as part of the cost of medical care it is quite evident that these organizations have greatly increased such cost and not reduced it.

DEFECTS IN MEDICAL INSURANCE*

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Century.

In life insurance the phenomenon insured is definite, likewise fire, tornado, wreckage insurance, and to a lesser degree human casualty insurance. The determination of liability of life, casualty, fire and tornado insurance companies is fairly easily arrived at, and recovery of the amounts due the insured is usually prompt. The fact that the phenomena are so definite prevents the insertion in insurance contracts of this nature, of ambiguous and evasive clauses.

Sickness insurance is almost the reverse. Most contracts cover total and partial disability. In every case of illness that incapacitates, the question of disability arises: when it began? when it ended? whether it is total or partial or both? and if both, when did total end, and partial begin and end? The very nature of this kind of coverage necessitates the writing of long, involved, ambiguous, and evasive contracts. This is necessary for the protection of insurance companies doing this kind of business against fraudulent claims. This being as it is, the insured is always at the mercy of the insurer. Public sentiment and the desire to continue business are the only measures of protection that the policyholder has. Many of the claims of which the speaker has knowledge have been viewed by the insurance carriers as fraudulent and have led to delays and investigation, and in many instances have been disallowed on account of some technical error, or the presence in the contract of some joker clause put in for that very purpose. Those insured

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, May 17, 1936.

often make fraudulent claims, or prolong their absence from work in order to collect insurance, alleging pains, or other purely subjective symptoms that cannot be disproved by the most learned physician.

These are defects inherent in this kind of business; it makes no difference who operates it, insurance companies, city, county, state or national governments, or voluntary societies. There is the disadvantage also to the insured of having to carry the overhead expenses in case of government or voluntary societies; and in the case of insurance companies the addition of profits to the owners. The policyholder pays for all mismanagement and errors of investments.

Aside from the fraudulent aspects, it is bad in principle even when honestly conducted. This is so because the happening insured is often indefinite, the duration not determinable and always more or less controversial when claims are made.

A few years ago, many old line life insurance companies wrote sickness clauses in their life policies for small premiums. On account of the unsatisfactory nature of the business, I understand that it has been discontinued by most of the reliable companies. This is sufficient to stamp it as an unsatisfactory business and needs no further argument. The discussion above shows its defects so far as the policyholders are concerned.

The physician opposes it on the following grounds: it disturbs the patient relationship to the doctor by introducing a third party into the transaction; it puts him more or less in a judicial capacity, for which he has no taste or training and he stands to lose the friendship of the insurance company or the patient, perhaps both, in every case of illness. There are certain traits of human nature that never change. Among these are gratitude and a desire to repay favors. If the doctor is paid by the insurance company it will be human for him to lean toward the company, and if he is paid by the patient, it will be vice versa. Therefore, it is embarrassing for an honest physician to be placed in such a situation.

The State, through insurance departments and courts is, and should be, interested in sickness insurance contracts. I take it as an axiom that no government, city, county, state, or nation, should enter the insurance business or, for that matter, other business except that which is purely governmental. Therefore, we will not consider government as an insurer, but as a regulator of the insurance business. Sickness insurance contracts must be very hard of adjudication. Well-trained physicians often are unable to determine when a person is sick and, if sick, the degree of disability. How much more difficult this must be for insurance departments and courts to determine! Pain, dizziness, nausea, headache, even lameness and many other symptoms of which people complain, are not objective and must be accepted or rejected, according to the attendant circumstances. You can readily see, therefore, that these defects make this business unsatisfactory from the State's viewpoint.

Lodge, and other lay plans of sickness insurance, have existed for many centuries. At first they were on the plans of mutual aid societies, and were cash payments for loss of time and only indirectly had to do with sickness. This cash payment became differentiated into that for loss of time and for payment of the costs of sickness. Then lodges or societies began to select physicians to do this work. Following this there was a mad scramble to get these positions, by underbidding, or other undercover methods, until the situation became intolerable. This seems to have reached its worst in Germany, and more than fifty years ago, the government entered the insurance business in order to correct the situation. Under the lodge practice the service had deteriorated by reason of the underbidding, and consequent cheapening of the service and overwork. The German government in taking over the business attempted to parcel out the work among the physicians. But this did not correct the abuses; it only gave a sort of legal sanction to them. A great government beaurocracy has been built up, that uses up a good deal of the funds that should go for sickness. The condition today in a way is even worse than it was when the government took it over. The initiative of the medical profession has been weakened, and the trust and confidence of the patient in his doctor has been shaken.

England has had social or sickness insurance for over twenty-five years. The plan in this latter country is better than that of Germany, but here again it is far from satisfactory. The same abuses are present: too many patients, trivial demands on the doctor, reporting and recording of trivialities that are of no scientific, social or political importance, but merely to satisfy the

demands of the government bureau or commission.

In Prague in 1926 there was a symposium by public officials, physicians, and society representatives on the workings of (sickness) insurance in Germany, Austria, France (before the present law), Great Britain, Switzerland and Czechoslovakia. It was admitted that sickness had increased, or at least time lost from sickness had increased, and consequently the cost of medical attention, drugs and hospital costs.

This shows clearly that there are human traits that cannot be controlled by law, education, or by preaching, and that there are always a sufficient number of unthinking and selfish people to wreck any honest scheme of sickness insurance.

The discussion further showed that there was a tendency to establish clinics and select certain groups of physicians to operate them. The physicians were often political appointees. This, no doubt, was brought about to conserve the financial resources of the insurance companies, and Kranken Kassen, or as we would say Sickness Societies. This, of course, prevents free choice of physicians and destroys the mutual relations, trust and confidence, that should always exist between the patient and physician. It leads to friction between the patient and insurance companies, the doctor and insurance companies, and sickness societies and insurance companies; and also between insurance doctors and those not so employed. So far as I know no country has been bold enough to enact a law that would force physicians to do this class of work, although Germany closely approaches it. Under all the schemes of sickness insurance as they now exist in all countries having such insurance the well-to-do and rich have free choice of physicians, whereas, the poor and indigent have very little or none. This varies in different countries, it being perhaps worse in Germany, Austria and Czechoslovakia.

The bargaining, and underbidding, as a result of this business has caused many physicians to have barely a subsistence. The insurance is fixed, but the equipment, cost of education, post graduate work, and demands on the physicians have increased. This is found to lead to inferior service, and the helpless poor will be the sufferers.

In the interest of constructive criticism, if the government wishes to help people who are incapable of helping themselves, have them put aside a small sum of money each month, or year, for sickness, with some designated custodian, these funds only to be used in case of sickness, but to always remain the property of the individual. This would always enable him to be a free man, and to have the choice of his physician. The payment for sickness should never have any relation to payment for loss of time.

A SYNOPSIS AND CRITICAL ANALYSIS OF SICK INSURANCE AND COST OF MEDICAL CARE*

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In the ten preceding discourses on Medical Economics, Insurance Medicine, Social Medicine, State Medicine, or any similar name, all meaning basically the same, there is a tremendous question raised. This question is threefold: first, is it (state medicine) best for the general public; second, would it harm the medical physicians individually or as a class; and third, would it eventually work out to the detriment of the advancement of medicine? If these questions could be readily answered, there would be little or no argument, but they *cannot* be easily answered, and there *is* an argument.

Before going into the subject, I wish to state a fact. With few exceptions, whenever a physician argues against State Medicine, he does so with the idea of protecting either the general public, or his own science, or both, and not his own income. There may be some in this audience who doubt this, but if you study the question, compare the countries who have State Medicine, you will find that under many systems the doctor's income is actually *increased*. Why shouldn't it be? Look at it this way—there are few physicians, whether old or young, rich or poor, successful or struggling, who do not do some, or much, charity work, work for which he does not charge, nor count upon as an asset. These charity patients are not the "beats" that could, but won't pay, but those actually without funds. Now suppose State Medicine or Insurance Medicine paid the bill for these patients; suppose the fees paid *were* only a fraction of the doctor's usual charges—would not the addition of small fees where none existed before, increase the

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, May 24, 1936.

general total income of the doctor? Of course it would. Then why do the real physicians, the general majority of the medical doctors, all practitioners of medicine who are not prostituting their practice for the sake of the dollar, bitterly oppose any form of insurance medicine? Why? Because they are true scientists, they have more interest in their patients, in other words, you, the general public, than in their collection of dollars. I will admit the occasional doctor will not feel this way, but you all should be as thankful as we are that this kind of doctor is the exception, rather than the rule.

This discourse is not just talk, nor even a one-man's opinion, but facts proven by years of experiment in other less fortunate (up to this time), countries than ours. You have heard what State Medicine is, you have heard where it is being made to function, and with what success, and in these past talks you have undoubtedly gained the idea that your doctor, and your neighbors' doctors are against it. And rightly so, because your doctor knows that just as soon as State Medicine would start to function he would cease to be *your* doctor, but would be a company or state doctor, and you, just one more patient to get rid of in as quick and easy a manner as possible.

The proponents of State Medicine paint in glowing colors, the benefits to be derived from a company dealing in sickness, but that is *before* you are sick and need aid. You, who are the people who pay in a small amount of money per week, month, or year, *actually own the company,* but that is lost sight of, and very shortly the officers of the company, your company, these officers, your paid servants, think and act as if *they* were the owners, and you the employees. It does not matter if the company is the State or National Government itself, it is just the same. It has worked out in other countries that these large companies grow into great political organizations, and actually work against you, the people, who have and really are, the money bags that these company officers use. It is just as if you hired some one to pick your pockets. You earn your money, pay someone to take it away, and you have nothing for it.

In some countries the insurance societies allow the people to join or not as they choose, in others it is compulsory to join. Some countries make a certain community of people go to certain doctors, in others you may choose your doctors. The free choice is the best, of course, and it is doubtful if this country, no matter how strong Uncle Samuel may be, would ever submit to compulsory anything, but the people of this country are very prone to try to get something for nothing. This, my friends, is impossible—you never get anything worth while for nothing, whether merchandise, advice, or medical treatment, and you never will, except, of course, if you are very poor, and then all charitably inclined people will do and give. But these great companies are far from dealing out charity. Their commodity is sickness. They buy and sell in it, and each illness, each death, is counted upon in terms of dollars and cents. Do you want your ills, your children's ills, treated in terms of dollars, pure commercialism, or would you prefer to have your own family physician or the specialist of your choice, administer with knowledge, kindness, understanding, and care? The one is dollars, the other is human interest, kindness, and pride in seeing you and yours get well.

You may have been told that a form of health insurance helps the county by keeping the sickly person well, and the number of sick and absent from work to a minimum. Nothing is further from the truth. The figures show that after health insurance is inaugurated, the number of sick steadily grows to even 100% or more, over normal. This is an attempt to get some returns on your money. It comes about in this way. The time comes when you have paid and paid, and not having been sick, you resent the fact of paying and determine to get some money back. You may have some slight ill, or fancied indisposition, and you promptly apply for benefits and stop work. This increases the numbers of sick and adds to the long line of unemployed. You derive no good from medicines not needed, nor idleness not deserved, and industry suffers from lack of your efforts; this is a boomerang because you eventually pay in the terms of advancing prices of commodities. No, my friends, you cannot manufacture dollars, you cannot normally get double from a single investment, nor can you get consideration from a vast political machine, such as a State Medical Bureau inevitably becomes. Look around you at the immense amount of bureaus that have recently been created. Who is going to pay for them? You, and no one else. Do you want some commercial or business man to sit in Washington or Tallahassee, and tell you what

doctor to have when you are ill, and then to tell that doctor what he can or cannot do for you, you, who are ill and suffering? I quote from a speech made by the General Medical Council of the International Bureau of Labor, which reads: "The institutions of insurance which have the responsibility of distributing services to the insured and maintaining the financial balance of their budget, should have the right to *control* the *patient* and the *practicing physician.*" Would you want this, talking of your sickness in terms of "balancing a government budget"? Do you think any government agency could control *your* illness, or *should* control your doctor's attendance upon *you?* You promptly answer no, and yet that is what state medicine is, and will be, unless you start to think and unreservedly back up your physician in his fight to protect you.

Why is smallpox rare, why is typhoid fever becoming more unusual? Why is diphtheria today rarely fatal? Why is a major operation no longer almost certain death? Why do you discuss vitamins, endocrines, and "cold shots" vaccines, and such like, in everyday language, and more or less understand them? Because some commercial governmental bureau discovered the cures and preventions? Because some one of the cults spent long years in research and then gave them to you for nothing? No. Your own physician, and hundreds like him, have studied, worked, and researched, to make all this possible for your benefit. Would you smother this under a commercial blanket?

Why have the past three decades of physicians given so many new, startling, and lifesaving methods and treatments to the world? Do you think your physician would do so, given the opportunity? Certainly. But let all physicians be treated as, and actually be, a paid employee of a great government agency, would these discoveries and advancements be made? Probably not, because their individuality, and their personal responsibility to the patient and public would be gone; incentive would be blunted; and the cold dollar, not your life, not your recovery, not advancement of medicine, would be considered, but the pure, good, old simoleon would be the object. That and getting through as quickly as possible, would be the consideration, with a check for the money paid at the end of a commercial workaday week. Lord Horder has said: "It is possible, nay easy, to see a great number of patients and yet not see their diseases." Would you want your doctor to run his establishment as does your grocer, or your plumber? Can you get sick during "hours", do you want to wait until the doctor "opens up for business"? This is very little exaggeration of Social Medicine as practiced in Europe.

Commercially the employer owns the goods produced and has the function of marketing them. He seeks, through salesmanship, to secure the choice of his goods by the buyer, among all goods offered on the market. Commercially the buyer has been taught that he must "beware" in dealing with the seller. He is supposed to be able to judge of the quality of the goods on the market, and is considered derelict in his duty if he does not use whatever knowledge he possesses in such judgment. If he fails to judge correctly, he often has practically no legal recourse. Medical services, however, differ widely from this commercial basis. They are not, or should not be, sold by a third party on a general market through salesmanship. The third party is not able to judge of the service.

Almost all of the features of sickness insurance as it exists at present, seem designed to destroy these characteristics that have always been considered the essentials of good medical service. Destroy personal feeling of physician to patient, destroy incentive, and destroy desire for medical advancement.

A last point in argument. Can a physician practice his art and be a policeman, or detective, at the same time? In State Medicine many are the fraudulent claims as to sickness and injury. If one is paying for service they will not likely pay to be cured of something they do not have. *But* in insurance the desire "to get theirs" creates a vast multitude of fake ailments. The physician must act as a stop to this kind of drain on the government or company's treasury. German commentators refer to this as the Sphinx riddle of insurance, which must be solved if the system is to continue, but for which no satisfactory solution has yet been found. A consequence of this is the creation in every insurance scheme of a secondary system to control the practicing physician. This group constantly reverses the practicing physician's opinion, creating disagreement, but what is more important, supposing your physician said you were sick and you *are* sick, but a "higher up" who did not know you said you were not. What would you do? You

would fight or appeal. Yes, and during this time you took some remedy you had before, or some of your grandmother's remedy, and in the course of time recovered. When your case came up for "trial", you had recovered, you are well, and the decision would, therefore, be to agree with the "higher up", you would either be fined as trying to defraud, or you would not be paid compensation for time out of work. How would you like it? This is but another phase of State or Bureaucratic Medicine.

In Germany and Austria, the physician, and consequently the people, have nothing to say concerning the great Social Medical Insurance societies, or how they shall deal out medical service, although they (the people) are paying for it. In Great Britain, Denmark, and France, the situation is somewhat better, but only because the physicians have been powerful enough to force certain rules on the question of insurance, and have secured representation on the various controlling boards. This is to protect the people directly, and to protect and keep up the advancement of medicine to new achievements.

Remember, any quotations from the International Labor Conference you may hear, or see, present a one-sided argument, are always for the bureau control, and never take you or your private physician into account.

I am reminded of a news cartoon of a great candle burning. Around its base are numerous scorched little moths labelled "foreign currency expansion"; still flying are some labelled "pay bonus with green backs"; and others, "inflate and save the farmer". There might well have been some more dead moths around the candle labelled "foreign social medicine" and others flying labelled "United States proposed state medicine", because these latter little moths will surely be burned the same as their foreign brothers. Why try a scheme or schemes that have so woefully failed in other countries. Are we such bigoted, swelled heads, that we know it all and every other nation is wrong, or are we to be led through the nose by a commercial bigoted government politically controlled machine?

Stand by your doctor, and he will be *able* to stand by you, but if you do *not,* no matter how he wishes, your doctor cannot stand alone.

This, and preceding nine papers on the same subject will be published in the July issue of the Florida Medical Journal. Look for it, study the subject, and do your part. If you do, or do not, agree, write in your comments to the Journal office, Jacksonville, or to this station. Those doctors of medicine or interested parties outside of the State of Florida, who wish copies write into this station or to the Journal office in Jacksonville.

THE LAYMAN'S RESPONSIBILITY IN THE CONTROL OF CANCER*

HENRY C. DOZIER, M.D.,
Ocala.

Cancer is an old disease, known and recognized as far back as the ancient Persians and Egyptians, but only for the last twenty years has it been considered as a public health problem. About twenty years ago, cancer occupied sixth place among the diseases listed in statistics as cause of death—at the same time tuberculosis was listed in second place. Today, however, these two diseases have changed places, and tuberculosis is now sixth, and cancer has risen to second place.

There are many reasons for this—first among which is the systematic educational campaign which has been waged against tuberculosis and cancer both in and out of the profession—which has made the people more cancer conscious, the doctors more efficient in early diagnosis. Also, as a result of the scientific advancement of medicine, there are more people living to the cancer age.

If we are to conquer this disease, there is one thing that is more important than anything else, which is *early diagnosis* or the early and proper treatment of conditions which, if neglected, may later become cancer. This can be accomplished by the profession only through the intelligent cooperation of the patient in seeking medical advice, when anything arises in his health which is suspicious or differs from what he knows is normal.

I wonder if there is anyone who has not heard and smiled at the amusing tale of the ostrich who buried his head in the sand when it had reason to suppose danger was in the neighborhood. The absurdity of this tale has made it a classical illustration of foolishness. But there are thousands of people who are acting today about cancer as the ostrich did about its enemies. They are hiding the truth from themselves as though by doing so they were insuring themselves against the consequences. What they are really

*Radio broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, April 15, 1934.

doing, however, is to greatly increase their danger.

To help people to avoid this danger, is reason for this talk in the regular series of Florida Medical Association broadcasts from this station. We felt that there were simple facts which, if put in the possession of the general public, would lead to the early recognition of cancer symptoms and thus make possible a cure. Probably the question that is uppermost in the minds of all of my interested listeners, especially if this disease has struck in or near your homes: Is cancer curable? The answer is, yes; cancer is curable in nearly all of its various forms, though only in its early stages, while it is still a local disease.

To cure cancer it is necessary that its existence be discovered at the earliest possible moment. After the disease has once become established and has spread through the body by the blood stream or the lymphatics it is almost always too late to stop it. Most people do not know this. They think that there is no use doing anything to get rid of cancer until the growth becomes painful or troublesome. Some people make a terrible mistake, for time is the most important single factor in the cure of cancer, because when such a growth becomes painful, it is almost always too late. Cancer is like a fire; when it is local and small it may be extinguished, but when it becomes a conflagration nothing short of heroic measures can control it.

The way to fight cancer is with knowledge, which means that the best method then is to tell people in simple language the early signs of cancer and urge those who think they may have these signs to go to their family physician immediately. They will find, more often than not, that the trouble is not really cancer but something *less serious* and so will have their fears relieved. There are many thousands of men and women who have a secret suspicion they may have this disease yet will not take the necessary steps to find out. They do not have the courage to face the truth. If they do not have cancer the truth will relieve them, and if they do have cancer the discovery may save their lives. Neglected cancer is inevitably and invariably fatal.

The treatment which is sometimes best for cancer is the surgical removal of the growth while it is still small. The other effective methods of treatment are *x-rays* and *radium*. Surgery removes the growth from the body, while radiation (x-rays and radium) destroys it in the body. Disappointing as it may sound, if people are to be cured of cancer, even in its early stages, they must know that no magic shot of serum or glandular extract, or drug has thus far been able to prove its curative value, when tested by large number of cases. Chemical or sloughing pastes and salves have long since been abandoned by intelligent physicians. Surgery (the removal of the tumor or growth), the electric cautery, radium and x-ray still remain our curative agents, although even these successful methods may utterly fail, if not applied early. Please remember that cancer starts in a small way; that it causes little inconvenience and usually no pain in the beginning; that it may be located anywhere in the body and that it may progress to the incurable stage before it becomes painful.

How soon cancer causes serious trouble depends upon the location and the patient, for each individual reacts differently to this disease. If it is in the mouth, on the lip or skin, it is probably recognized as something serious, while it is small. Sometimes wart-like conditions, moles and old scars are the places where cancers begin. Any change in the size, appearance or sensitiveness of a mole or skin growth should receive attention at once.

Many people who know that they have a cancer are unwilling to do anything about it until they are absolutely compelled to do so. The annual toll of over 3,000 deaths due to skin cancer alone could largely be prevented if early treatment were obtained. This is true also of cancer in other accessible locations in the body. Fear keeps many of these people from seeking immediate treatment. Yet if the facts are known about the increasing number of permanently cured cancer cases, fear will disappear. End results in cancer treatment are improving constantly and approximately over 90% in early skin cases. Cures, however, can be obtained in large numbers only when the disease is still local. Human ostriches who persist in evading the truth, who hear these words and who do not act upon them at once, if suspicious signs of cancer are present, choose deliberately to neglect their chances for life. They form the countless army of patients to whom physicians can but say, "why didn't you come to me sooner?"

There is no more important message that can be given the public in relation to cancer than this: Early diagnosis and early treatment increases

chance of cure; delay in seeking treatment is dangerous. If you have persistent, unexplained *indigestion* and are over 40 years of age, insist on having x-rays taken at once; if you have a *lump in the breast* or bleeding from the nipples, see a physician immediately; if you have *a scaly patch* on the face or a *lesion which does not heal* on your lip or in your mouth, have an immediate examination; if you have a *black mole or wart which becomes inflamed* or changes in size, find out about it without delay; if you have any *abnormal bleeding from the body,* especially after change of life, go to a doctor without delay. These signs do not necessarily mean cancer, but they are suspicious and they demand immediate investigation. They are the signs at the cross-roads on life's highway, and must not only be *seen* but *read* and *understood* and *acted on,* if we are not to lose our way off the road which leads to health, long life and happiness. To read and heed these signs is both wise and courageous. To act in these cases means possibly the saving of many lives, and also would fulfill the layman's obligation in the control of cancer.

THE MECHANICS OF THE CIRCULATION*

J. Ralston Wells, M.D.,
Daytona Beach.

Is there any one who doubts that blood circulates through the body? Is there any one who does not know that the heart pumps the blood probably is not one per cent of all educated peo- regularly to every part of the anatomy? There ple who do not *know* these facts, or at least take them for granted, and yet this was a "discovery" of not so many years ago. A discovery? Can you imagine such a common thing as this being a "discovery"? No one questions that the world is round; few of us have taken the trouble to prove the fact, but nevertheless we believe it. So also few besides physicians and scientists have seen the blood circulate—these facts are taught and we believe them, forgetting that at one time they were unknown and had to be discovered.

However strange it may seem to us today, it was not until the year 1628 that Dr. William Harvey, an English physician, wrote his findings in regards to the blood and its circulation, revolutionizing the entire medical world and paving the way to further findings to help mankind. Prior to this time, there were many fanciful and mysterious theories. The heart was recognized as a vital organ, but acted merely as a mixing chamber; it was also credited with being the heat center of the body. It was believed that there were two kinds of blood channels, arteries carrying red blood, and veins carrying a more purple colored blood. That these circulated in a continuous flow, or circulation, was not known. The liver was given the credit of being the central source of the blood, and it was thought that the food was brought here and changed into "vital spirits," and that these spirits plus the blood were carried to the various parts of the body through an ebb and flow process like the ocean tide. To the blood was given various attributes by the ancients, especially in controlling and influencing dispositions and temperaments. Even today we use the terms "cold blood," "hot blood," "thick blood," "bad blood," "angry blood," etc., but these are without foundation of fact, the blood being one of the least living of all bodily tissues. It, per se, has nothing to do with our dispositions or temperaments.

It is a wide stretch of the imagination to think of the heart in its popular shape, unless this shape has been taken from a "broken heart" of some tender love-sick maiden. This conventional shape that we see on valentines might be conceded if the human heart be cut in half and laid open, but the heart in reality is more or less pear-shaped, and in a normal individual about the size of the individual's clenched fist. It is a quite regular mechanical pump equipped with regular valves; it pumps blood and nothing else, all the romantic qualifications to the contrary notwithstanding. It is quite insensible to the "tender emotions," and only pumps faster, or slower, at the dictate of the nerves controlling it. Therefore, this heart of ours is quite unromantic. It consists of a double pump—right and left. The left side, or left pump, sends the red blood through a branching set of elastic pipes, called arteries, to every organ and most minute part of the body—the further from the heart, the smaller the artery. When the smallest division of the arteries are reached, the blood passes from them to the smallest veins. These veins become larger as they go toward the heart, and gather in the contributing branches. The blood enters the heart on the right side of the double pump, is taken and pumped through the net-

*Radio broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, December 10, 1933.

work of blood vessels in the lungs, returned to the left side of the heart, and starts its circulation all over again.

This may sound very simple, or very complicated. It is neither the one nor the other, or it may be both, just as one looks at it. It *is* a *simple* flow of fluid moving by a natural law of being forced or pumped, but it *does* go through a complicated set of organs, and performs varied complicated functions. The more complex influences that govern this circulation are becoming clearer as new findings are added from time to time by the medical profession and research scientists. Let us trace some of the more common mechanics. We may arbitrarily commence with the left heart pump. This is set in motion, or contracted and expanded, by a series of nerve impulses supplied by the central nervous system through the nerves to the heart—the red blood is sent to all parts of the body—to the muscles, where it gives off oxygen and creates the heat for the body; to the bone marrow, where new red blood cell elements are added; to the spleen, where old worn-out cells are removed; to the kidneys, where the waste liquid is removed; to the brain, where elements for the brain's use are taken out; to the liver, where some sugar and other elements are removed; and so on, to all tissues and organs, giving and taking up as it goes, until it reaches the smallest calibre network of the arterial system in these various structures and organs. During this half of the circulation, it has given off elements necessary to replenishing all the bodily structures, has gathered much waste materials, which change its color from its own worn-out parts for new ones. It now enters the return flow, or venous system.

While gradually giving off oxygen gas, and food elements, it has taken up another gas, and waste materials, which change its color from bright red to a brown, or purple red, color. It returns sluggishly through the veins to the right side of the heart. Not having the direct pump, or thrust, of the heart, the blood in the veins does not flow in jets, nor is it rapid. It flows in a steady, continuous stream. In many of the larger veins, there are valves that are distinctly mechanical, but function only to prevent a back flow or stagnation in the smaller veins and arteries. After this used blood reaches the right side of the heart, the right pump forces it into the lungs where it exchanges its carbon dioxide gas and other waste materials for oxygen. It loses its purple color and again assumes the bright vermilion. As such, it returns to the left side of the heart, and starts its entire circulation again.

The nerve stimulation to the mechanical heart pump *is* complex, and suffice to say, during the blood circulation through the brain and spinal cord the waste materials in the purple blood act upon these central nerve centers, stimulating them in proportion to the amount of waste contained in the blood necessary to be thrown out. The more the need of new blood elements by the tissues, the more are taken out, and the more waste material deposited in the stream. This makes a more rapid flow necessary, which we often find expressed in a quicker beat of the heart pump as indicated by the pulse beat in the wrist, the neck, and elsewhere.

In fever, for instance, we have more heat, therefore more actual burning up, more waste, and more new elements necessary to replenish; so also in any violent exertion or exercise. These phases make more demand on the mechanical part of the circulation, resulting in a more rapid heart beat.

The pressure of the blood shows the force that the heart must expend to send this inert blood through the fine network of small arteries. Thus can your physician, or let me call him your physical engineer, tell in some measure whether your circulation mechanics are working properly and adequately in order to maintain health. The mechanics of circulation is only one part of an intricate machine called the human body.

What I have said is necessarily brief and fragmentary. If this broadcast has stimulated your interest in a most complicated subject, the intensely interesting and marvelous fluid of our "intricately and wonderfully made bodies," let me refer you to a very excellent work, "The Lame, the Halt, and the Blind." The author is Howard W. Haggard, M. D., and the publishers, Harper and Brothers—to whom I am indebted for some of the facts used in this talk. Read this little volume, and "tune in" on the bi-weekly broadcasts of the Florida Medical Association, and you will learn much about the scientific bases on which rest our modern medicine as we know it today.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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REGIMENTATION OF PHYSICIANS

How very often does regimentation come up for discussion in gatherings of physicians! Yet, how many of us have deliberated upon this subject seriously and at any length? Only a few, doubtless. Rather are we all too prone simply to lay this vital matter at the door of the New Deal. In reality, it is as far from the New Deal as Hippocrates and his teachings are from the present era of medicine.

True it is that our era is most certainly undergoing a severe test. If regimentation or socialized medicine is to come, it is we who will be the originators, we ourselves who will be to blame. When we deliberately break the faith which the public has in us as physicians, then we alone are responsible for the peculiar position in which we may find ourselves. Every community in the United States has some local problem pertaining to the practice of medicine that we allow to exist. Where, indeed, is there concerted effort within our ranks to meet these difficulties which confront the individual communities? Unquestionably of doubtful ethics is the mass plan of practice in which physicians have for their clientele large groups of employees, as of large cotton mills, lumber companies and camps, chain stores, department stores, bus companies and other such organizations, also tenant farmers. This type of practice has nevertheless existed for years.

There is today prevalent throughout our whole land an uneasiness, a feeling of insecurity, a sense of depression. In consequence, no doubt, other types of practice, dangerous to our well-being, are finding a place in our midst. They are promoted, for example, by mutual aid societies and large clubs among the laity, which solicit members, charge weekly dues, offer a type of insurance and promise medical care and hospitalization. These organizations employ physicians to attend to the medical needs of their members and pay them a stipulated salary. Physicians themselves have fostered many of these organizations, and in numerous instances the individual physician has been the nucleus from which these semi-medical organizations have been able to grow and assume a place in the field of medical practice.

Also, there are numbers of organizations with medical care as an important factor, or indeed the sole feature, which are definitely practicing medicine. They employ physicians at a stipulated salary and themselves pocket the profits. Some of them have enjoyed phenomenal growth.

Since the physician has allowed himself to be drawn into such practice and has permitted these semi-medical organizations to gain such strength as they now have, the public has become increasingly conscious of this trend. As a result, every conceivable type of hospital and medical service is now being formulated.

Not the New Deal, not the present administration, in fact no lay group, is trying to regiment physicians. The interested laity is only thinking along lines laid down over a period of years by members of our profession who have espoused the mass plan as a means of making medical care less costly and more readily available. Who is responsible? Who is to blame? Who originated the ideas the layman now considers? Neither our government nor the present administration; neither our senators nor our congressmen. Right on our own doorstep the whole responsibility rests.

Not until the physicians throughout this great country of ours realize this fact, not until we evolve our own plan of medical care and establish our own methods of practice as we want them, will we make progress toward a real solution of the present problem. From within the profession come the socialistic tendencies which beset us. No authorized body of thinking people would attempt to regiment physicians or presume to interfere with the legitimate practice of medicine. We are assured that the practice of medicine will remain individualistic as long as

we, of the rank and file of the profession, make the problems which pertain to it our problems instead of fostering lay organizations and looking to them for a solution of difficulties peculiarly our own.

POLITICS

As long as we are under a constitutional form of government, it is most evident that as individuals we must do our part in government to support a policy that seeks to protect the rights of our profession and advance the effectiveness of applied scientific medicine. The exercise of the privilege to select members of law-making and law-enforcing bodies is a duty of good citizenship. The effort we make to learn the qualifications of candidates and the help we give to elect the proper representative officials is what is meant by politics.

Office seekers are most mindful of the wishes of any considerable voting strength. They will most likely not oppose the wishes of a strong group. Since the Ocala meeting, our profession has become more conscious of the abuses suffered and the dangers ahead in some of the proposed experimental medical practice legislation. To meet the issue, a group of the allied medical professions composed of physicians, dentists, druggists and nurses is being formed. Members of these professions, on the average, have not taken part as they should in politics. Necessity has forced us to enter politics for our protection and a wiser administration of applied scientific medicine.

In the past, we have too often been unable to secure the passage of sound sensible medical practice laws and have been compelled to accept unsound and even vicious laws sponsored by organized cults. The way out of this unfortunate position is to become active as a group and secure proper recognition and prevent this vicious legislation.

In the past few months every member of our profession must have recognized the possibilities of such an organization to help select capable representatives and have their support for more sensible and effective medical practice acts.

POST-GRADUATE MEDICAL INSTITUTES

In line with other efforts of physicians and health officials to reduce the maternal and infant mortality rates, the Florida Medical Association, in cooperation with its committee on Maternal Welfare, sponsored a series of post-graduate medical institutes from June 1st to June 16th, 1936, inclusive, featuring maternal and child health.

The institutes were conducted in cooperation with the local medical societies and were held in West Palm Beach, Miami, Fort Myers, Tampa, Lakeland, Orlando and Daytona Beach. Each institute lasted two days and consisted of afternoon and evening sessions.

The two lecturers, selected by a special committee representing the Florida Medical Association, are outstanding men in their professions. Dr. E. D. Plass, head of the Department of Obstetrics, University of Iowa, has contributed much to the literature on obstetrics. He is generally regarded as one of the outstanding teachers of obstetrics in the United States. Dr. S. F. Ravenel, pediatrician, of Greensboro, North Carolina, is a teacher of national recognition in his subject and for a number of years has participated in the summer courses in pediatrics at Saluda, North Carolina. Both men have given lecture courses in similar institutes in a number of other states.

The subjects covered in the lectures on obstetrics included prenatal care, certain complications of pregnancy, the toxemias of pregnancy, certain phenomena of labor and postpartum care. The lectures on pediatrics covered problems of the new born, infant feeding, diarrhea, the prevention and treatment of contagious diseases and tuberculosis in children. Each lecture included diagnosis and treatment and was followed by open discussion. A number of the lectures were illustrated by stereopticon slides.

Through the efforts of the local medical societies and the local newspapers, a representative group of local physicians and physicians of adjoining towns and counties attended each session. The visiting lecturers were well received, and the attending physicians expressed their appreciation of the valuable information received from the lectures and discussions.

Funds which made the institutes possible were secured by Dr. W. A. McPhaul, State Health Officer, from the Children's Bureau of the United States Department of Labor and are designated for the program of professional education.

Plans are being considered to extend these institutes to other sections of the state.

PUBLIC RELATIONS COMMITTEE

This issue of the Journal is somewhat unique in that it contains a series of articles on Medical Economics which has been written by a group of your members. The basis for these writings are not hearsay, but facts that have been gathered from various sources, and more particularly from voluminous literature that has been furnished by the American Medical Association. The talks have been well thought out, and it is hoped that they will be kindly received by everyone in the profession who reads them. While probably all the conclusions taken will not be agreed upon by every member, it should stimulate thought and constructive controversy.

The controversial side of the subject as furnished by the Rosenwald Foundation, is of so undermining a character insofar as organized medicine is concerned, that this literature was not utilized.

It is sincerely hoped that this series of articles will be used as subjects for debate in the various County Medical Societies during the coming year. The importance of organized effort to stem this rising tide of commercialism in medicine, is well recognized, but is, I am sorry to say, apparently little feared by government or politicians, because the profession as a whole will not agree unanimously on any one phase, nor does the profession as a whole in Florida, bother itself concerning state medicine in the future. And while I am not an alarmist, I think the time has come, is present, and is passing, when we, as a body, should assert ourselves, not only in the interests of the public and to protect our own incomes, but the research and scientific endeavors of medicine should by all means be of paramount importance. If we, as an organized profession in Florida, would, and could, agree on any set of principles concerning encroachments or poor legislation, or quack medicine, it would be almost impossible for the Federal Government, let alone the State Government, to *make* us do anything that we thought detrimental and did not agree to.

Medicine is like a slumbering giant, who, when aroused, would be unassailable. With this end in view the Public Relations Committee requests, and welcomes, criticisms in writing, and a copy of the County Society's secretary's notes, in which they have discussed this phase of medicine would be appreciated for the Committee's files.

J. Ralston Wells, Chairman,
Committee on Public Relations.

CORRESPONDENCE

W R U F
"THE VOICE OF FLORIDA"
State and University Station
University of Florida
Gainesville.

May 25, 1936.

Dr. J. Ralston Wells,
Chairman Committee on Public Relations,
Daytona Beach, Florida.

My dear Dr. Wells:

The time has come for me to write to you as Chairman on the Committee on Public Relations, of the Florida Medical Association, to congratulate you and the Florida Medical Association for the excellent instructive and helpful radio talks, which should by all manner be continued. You are rendering the people of the South, through the medium of radio, a distinct public service which has been very helpful and beneficial, not only to the people of Florida, but to the people of the entire South. Space does not permit my going into detail, but attention has been called where people through listening to these broadcasts have quit trying to cure themselves of ailments which they knew nothing about, and have gone to doctors to receive proper medical aid and attention. I could cite many instances which have been called to my attention.

You have likewise gone a long ways in correcting conditions that existed particularly in rural communities, thus rendering the people of Florida a great public service, of which every member of the medical profession should be proud.

It is my desire to congratulate you and your Committee and to sincerely say that I hope the Florida Medical Association will continue this excellent work through the medium of the radio.

If I can be of any assistance at any time I want you to call upon me. With kindest regards and very best wishes, I am

Faithfully yours,

Garland Powell,
Director.

STATE NEWS ITEMS

YOUR INVITATION. All members of the Florida Medical Association are invited to attend a "stag" picnic.

The Orange County Medical Society will hold its annual picnic and barbecue at the Dudsdread Country Club Saturday afternoon, August 29, beginning at two o'clock and continuing as long as you wish to stay. The Dudsdread Country Club has just completed one of the finest open-air swimming pools in the State and those wishing to take advantage of this feature should bring their bathing suits. The Orange County Medical Society now has two steers being fattened for this event and will also have plenty of Brunswick stew and other things necessary to make such an affair a successful one.

All members of the Florida Medical Association are cordially invited to attend. The Southeastern Surgical Congress will hold its meeting and clinic at the Orange General Hospital in Orlando on that day and, upon adjournment, will proceed to the picnic.

These picnics given by the Orange County Medical Society in the past few years have been enjoyed very much by those who attended and this year it will be bigger and better than ever. So the members of the Orange County Medical Society beseech you to participate in this, their annual frolic.

* * *

Dr. and Mrs. Meredith Mallory of Orlando spent some time during May visiting friends and relatives in Omaha, Chicago and New York. The latter part of June, Doctor Mallory left for Boston to take post-graduate work.

* * *

Drs. Paul D. Bird and R. L. Cline of Lakeland and Drs. Benjamin J. Bond and William E. Sherman of Winter Haven were in attendance at the Emory University post-graduate course during the week of June 1. Doctor Cline also attended the Eye, Ear, Nose and Throat post-graduate course at Gillmore Hospital in Roanoke, Virginia, during April.

* * *

Col. Raymond Sanderson, Medical Corps Reserve, U. S. Army, was ordered to active duty the first two weeks of July at the Medical Field Service School, Carlisle Barracks, Pa.

As this Journal goes to press, plans are nearing completion for the thirty-sixth annual meeting of the Chattahoochee Valley Medical Association to be held at Radium Springs, Albany, Georgia, July 14 and 15. Two thousand invitations have been issued to doctors of Alabama, Georgia and Florida. For the year just closing, Dr. Robert B. McIver of Jacksonville served as president of the Association and Dr. Edward Jelks, also of Jacksonville, was a member of the Council. Among the speakers for this meeting are: Drs. W. W. Kirk, J. M. Bryant, Ferdinand Richards, Lucien Y. Dyrenforth, J. W. Merritt and W. A. McPhaul of Jacksonville and Dr. C. D. Whitaker of Marianna.

* * *

The First International Conference on Fever Therapy, originally scheduled for the end of September, 1936, has been postponed because of numerous requests, to permit more time for the preparation of material. The new dates set for this Conference are March 30th to April 2nd, 1937. The sessions will be held at the College of Physicians and Surgeons, Columbia University, New York City.

* * *

The meeting dates of the Sixty-Third Annual Convention of the Florida Medical Association have been set by the Executive Committee as April 5, 6, and 7, 1937. The Vinoy Park Hotel of St. Petersburg will be used as headquarters.

* * *

The many friends of Dr. Edward Jelks of Jacksonville will regret to learn of the death of his father, Exum N. Jelks, on July 13. Mr. Jelks for the past 14 years has resided at Pompano where he had large land holdings.

* * *

Secretaries of all component county societies recently received a letter from the Association's secretary requesting a copy of the constitution and by-laws of their societies. At the last meeting of the House of Delegates, action was taken to the effect that a copy of the constitution and by-laws of each component society shall be on file with the Association's secretary. County society officers are urged to comply as early as possible.

The following members of the Florida Medical Association registered at the Annual Meeting of the American Medical Association, held in Kansas City, May 11-15, 1936:

Bryans, Herbert L. Pensacola
Chandler, Gail E. Miami
Coplan, Milton M. Miami
Dickinson, J. C. Tampa
Eskew, Don C. Miami
Ferrara, John D. Jacksonville
French, Elmo D. Miami
Goodson, W. M. Miami
Halton, Joseph Sarasota
Herpel, Frederick K. W. Palm Beach
Johnson, Vesey M. W. Palm Beach
Lefholz, Rothwell Miami
Lyell, R. O. Miami
Mallory, Meredith Orlando
Martin, L. W. Sebring
Marr, Norval M. St. Petersburg
Murphy, David R., Jr. Tampa
Netto, Lloyd J. W. Palm Beach
Nichol, E. Sterling Miami
Orr, Louis M. Orlando
Panettiere, Cayetano Miami Beach
Pound, J. H. Chattahoochee
Robertson, J. C. Chattahoochee
Sams, Wiley M. Miami
Snyder, John W. Miami
Taylor, B. E. Orlando
Taylor, H. Marshall Jacksonville
Webb, Carol C. Pensacola
Winchester, H. E. Dunedin

* * *

The many friends of President Feaster will regret to learn of the death of his father, Otis Feaster, who, for the past seven years lived in St. Petersburg. Mr. Feaster died at a local hospital on July 7.

* * *

Ninety-nine Florida physicians, representing 47 towns registered at the Fourth Annual Post-Graduate Short Course at Gainesville, July 22-27, 1936. These men were enthusiastic in their praise of the program arranged and expressed surprise that more of their colleagues had not taken advantage of this opportunity.

A list of the doctors attending and a summary of the lectures will appear in the August Journal. Watch for them.

* * *

Dr. Ralph E. Stevens of St. Petersburg has been appointed chief physician at the Florida State Hospital, Chattahoochee. Doctor Stevens succeeds Dr. J. H. Pound who recently resigned.

* * *

Dr. Frank G. Slaughter of Jacksonville was the speaker at the local Lions Club at its luncheon on July 10. Doctor Slaughter spoke on "Treatment of Tuberculosis."

Drs. Walter C. Jones and F. A. Vogt of Miami attended commencement exercises at Emory University in June.

* * *

Dr. Ralph Vallotton, who for some months has served as Institution Physician at the Florida State Farm, Raiford, sailed in June for Vienna where he will take post-graduate work. Doctor Vallotton expects to return late in September.

* * *

Dr. Dalton Y. Rosborough, for many years a resident of Palatka, died in a Jacksonville hospital on July 3rd.

* * *

Dr. Austin J. Kemp of Miami died at his office on June 8.

* * *

Dr. H. M. Strickland of Live Oak succumbed to a heart attack on July 1 at his camp on Blue Lake.

* * *

Dr. Jesse J. Saxton of Tampa died at Jacksonville on June 29 as a result of injuries sustained in an automobile accident which occurred on the Gainesville road two days previously. Dr. C. A. Andrews of Tampa was injured in the same accident.

* * *

Dr. Paul D. Bird of Lakeland was painfully though not seriously injured in an automobile accident near Twin Lakes, 10 miles south of Valdosta, Ga., on June 7th.

* * *

Dr. Bascom Palmer and family of Miami spent their summer vacation in the West. Among other points of interest, they visited Yellowstone Park.

* * *

Dr. J. S. Turberville of Century was recently elected vice-president of the Southeastern Surgical Congress at a meeting held June 18 in Atlanta, Georgia. Louisville, Kentucky was selected for the next meeting of the Congress.

* * *

ERRATA

At the end of column 1, page 513, May, 1936, Journal, the report of Dr. Julius C. Davis, Chairman, Committee on Medical Education and Hospitals, should read, "With allocation of part of racing track money to hospitals for caring for indigent patients." Through an error "savings bank" was printed in place of "racing track."

Dr. J. C. Davis, Quincy physician and surgeon, was honored by his fellow alumni of his alma mater in Atlanta recently when they elected him as president of the Emory University School of Medicine Alumni Association at the centennial celebration and home coming, attended by more than five hundred graduates from this high ranking school of medicine, representing about twenty states. The honor came as a complete surprise to the former president of the Florida Medical Association and present member of the board of medical examiners of Florida. Dr. Davis was on the program for a lecture on the subject of acute intestinal obstruction, being the only person not a member of the faculty to be so recognized.

* * *

Dr. Lawrence A. Klein announces the removal of his office from Jacksonville to Osceola, Florida.

* * *

Dr. J. S. Turberville of Century and Doctors Frederick J. Waas and Gerry R. Holden of Jacksonville attended a meeting of the Executive Council of the Southeastern Surgical Congress in Atlanta on June 18.

* * *

Dr. Duncan Owens of Miami Beach spent a pleasant vacation in New York and Canada recently.

* * *

The Florida East Coast Medical Association will meet this year in Fort Pierce the latter part of October or early part of November, the exact date to be announced later.

At a preconvention meeting of the Florida East Coast Medical Association held aboard the S.S. Florida, it was decided that since Fort Pierce was within four hours' driving time of all of the members, that a one-day meeting would be held, beginning at ten o'clock Saturday morning and lasting through the banquet and dance Saturday evening, allowing Sunday morning for those who care to play golf, fish or participate in other relaxations.

If you have a paper you would like to present please send the title and synopsis to the secretary, Dr. E. B. Hardee, Vero Beach, Florida. An executive meeting will be held about the first of August, at which time the program committee of the Florida East Coast Medical Association will select the papers to be presented.

Dr. Meredith Mallory of Orlando and Dr. Herbert L. Bryans of Pensacola represented the Florida Medical Association in the House of Delegates of the American Medical Association held at Kansas City, May 11 to 15.

* * *

Dr. Gerry R. Holden of Jacksonville was a guest speaker at the regular meeting of the Fulton County Medical Society, Atlanta, on the evening of June 18.

* * *

Dr. Iva C. Youmans of Miami has sailed for the Orient. While away she will visit Egypt, Greece, Russia, Germany and France where she will attend various clinics.

* * *

Dr. E. M. Coleman of Groveland announces the removal of his offices to Clermont.

* * *

The annual clinical meeting, Florida section, of the Southeastern Surgical Congress, will be held in Orlando on Saturday, August 29. All members of the State Association are cordially invited to be present.

The program is composed entirely of clinic discussions upon cases which will be presented. Dr. J. S. Turberville of Century, Chairman of the Clinic Committee, will preside. The local committee is composed of Doctors Frank Gray, Chairman, J. R. Chappell, L. C. Ingram, John S. McEwan, and L. M. Orr.

All meetings will be held at the Orange General Hospital. The hospital is cooperating most graciously in the arrangements for this meeting. All those in attendance at the meeting will be the guests of the hospital at lunch.

The clinic will adjourn promptly at four o'clock in order to allow every one to attend the annual barbecue of the Orange County Medical Society which is being held that afternoon.

While the entire program has not yet been completed, it is expected the following men will have places on the program: Dr. O. O. Feaster, St. Petersburg, President of the Florida Medical Association; Dr. Edward Jelks of Jacksonville, President-elect, Florida Medical Association; Dr. Walter C. Jones, Jr., of Miami; Dr. Leland F. Carlton of Tampa; Dr. J. K. Quattlebaum of Savannah, Georgia; Dr. T. C. Davison of Atlanta, Georgia; Dr. J. C. Patterson, Cuthbert, Georgia, and Dr. Roy Nolan of Fairfield, Alabama.

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COMPONENT COUNTY SOCIETIES

COLUMBIA COUNTY MEDICAL SOCIETY

THE COLUMBIA COUNTY MEDICAL SOCIETY RECENTLY BECAME THE FIFTEENTH SOCIETY TO BE PLACED ON THE HONOR ROLL. 100% OF DUES FROM THIS SOCIETY HAVE BEEN PAID FOR 1936.

* * *

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held at the Rod and Reel Club recently, Dr. O. O. Feaster, president of the Florida Medical Association, was guest speaker.

A called meeting was substituted for the regular monthly meeting of the Society on June 4 in order that the post-graduate lectures by Dr. Sam Ravenel and Dr. E. D. Plass might be delivered in regular meeting. The great interest of the members was shown by the many questions propounded. Following the lectures, non-members were excused and a business meeting was held.

* * *

LAKE COUNTY MEDICAL SOCIETY

Dr. J. S. McEwan of Orlando was guest speaker at the meeting of the Lake County Medical Society held June 1. He presented an interesting paper on "Traumatic Surgery."

* * *

ORANGE COUNTY MEDICAL SOCIETY

All members of the Florida Medical Association are invited to a "stag" picnic which will be held Saturday, August 29 at the Dudsdread Country Club, Orlando. A write-up of this picnic will be found among the news items of this Journal.

The Orange County Medical Society held a buffet supper at the Orlando Country Club, Saturday, June 27. There were sixty doctors in attendance, about half of them coming from the surrounding cities of Daytona Beach, New Smyrna, DeLand, Sanford, Eustis, Leesburg and Kissimmee. The program was interesting and instructive, consisting of answers by Dr. Emil Novak to questions on gynecology and obstetrics. Doctors Novak and John A. Tompkins, both of Johns Hopkins Medical College, Baltimore, were honor guests of the society at this meeting, having come to Orlando at the close of the post-graduate course at Gainesville. They were later entertained in the sport of sea-fishing by some

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* * *

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The members of the Pasco-Hernando-Citrus County Medical Society were guests of Dr. W. E. Mitchell at Fort Dade Park in Bushnell, Thursday, June 11th.

Following an interesting tour of the Park, a splendid dinner was served at the Park Lodge followed by the regular business and scientific meeting.

The following members were present: Dr. G. R. Creekmore, Dr. S. C. Harvard from Brooksville; Dr. A. B. Cannon, Lacoochee; Dr. Geo. Dame, Inverness; Dr. A. B. Albritton, Wildwood; Dr. T. K. Slaughter, Wildwood; Dr. L. A. Carter, Bushnell; Dr. G. W. Wood, Oxford; Dr. W. E. Mitchell, Coleman; Dr. W. W. Jones, Dr. J. T. Bradshaw, and Dr. J. J. Bourke, Dade City.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

The members of the Pinellas County Medical Society enjoyed an outing at the Lakewood Country Club on June 4. Golf, the diversion of the afternoon, was followed by a dinner dance.

Dr. Annette M. Bieker presented a paper on "Ultraviolet Ray in the Treatment of Erysipelas" at a meeting of the Shrine Club of the Pinellas County Medical Society, June 19. Drs. L. M. Gable and R. H. Knowlton led the discussion.

THE PINELLAS COUNTY MEDICAL SOCIETY HAS REPORTED 100% OF ITS DUES FOR 1936. THIS SOCIETY IS NOW THE LARGEST WITH A FULLY PAID MEMBERSHIP, HAVING 81 ACTIVE MEMBERS ON ITS ROSTER. CONGRATULATIONS, PINELLAS COUNTY SOCIETY!

* * *

ST. JOHNS COUNTY MEDICAL SOCIETY

THE ST. JOHNS COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR THIS YEAR. THIS SOCIETY IS HEADED BY H. E. WHITE, PRESIDENT; G. W. POTTER, VICE-PRESIDENT; R. D. HARRIS, SECRETARY, AND A. C. WALKUP, TREASURER, TO WHOM MUCH OF THE CREDIT FOR THE SPLENDID CONDITION OF THE ORGANIZATION MUST BE GIVEN.



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VITAMINS IN CANNED FOODS

I. VITAMIN C

• The history of scurvy is as old as the history of exploration and conquest. Its ravages among early explorers and invaders are recorded in the oldest pages of history, due principally to the fact that during extended sea voyages or treks by land, dependence had necessarily been placed almost entirely on foods preserved by the crude methods of the day.

Scurvy was the first vitamin deficiency disease to be controlled by dietary management. In 1757, Lind recognized the fact that some substance in foods exerted a specific protective action against scurvy (1). As early as 1804, the daily lime juice ration became compulsory in the British Navy (2).

However, it remained for modern biochemical science to establish the chemical identity of this antiscorbutic factor. Vitamin C is now known to be identical with cevitamic acid (levo-ascorbic acid) and is as yet the only vitamin to be synthesized in the laboratory (3).

There would appear to be no valid reason why scurvy should ever constitute a serious threat to the health of the average American infant or adult. Development of refrigerated transportation for raw foods and improvements in modern methods of food preservation, specifically canning methods, make available to the consumer during the entire year a large variety of foods possessed of valuable vitamin C contents. In addition, the modern trend towards education of the layman, in regard to the vitamin C requirements of both the infant and the adult, should also assist in complete eradication of infantile and adult scurvy from America.

Many canned foods are to be valued as contributors of vitamin C. Nutritional research has indicated that canned products such as the citrus fruits or citrus fruit juices (4), the more common fruits (5), and vegetables or vegetable juices, are important sources of the antiscorbutic factor (6). Modern canning procedures afford a good degree of protection to this labile vitamin, with the result that the canned food can be relied upon to supply amounts of vitamin C to the diet consistent with the amounts of the vitamin originally contained in the raw food from which it was prepared.

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(1) Vitamins: A Survey of Present Knowledge. Page 187 Medical Research Council, Special Report 167. 1932. His Majesty's Stationery Office, London.
(2) Vitamins in Theory and Practice. Page 86, L. J. Harris, 1935. Macmillan, New York.
(3) 1933 J. Chem. Soc. *136*, 1419.
(4) 1930 J. Home Econ. *22*, 588.
(5) 1935 Amer. Jour. Pub. Health, *25*, 1340.
(6) 1933 Ind. Eng. Chem. *25*, 682.

This is the fourteenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

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Mrs. L. C. Ingram, Parliamentarian *Orlando*

COMMITTEE CHAIRMEN

Mrs. Wilburn Lassiter, Press and Publicity *Gainesville*

My Dear Friends and Auxiliary Co-workers

As your president for the coming fiscal year of the Woman's Auxiliary to the Florida Medical Association, I extend to you my most sincere greetings and best wishes, trusting that our year together may be one of happiness and achievement. I wish to express to you my gratitude for being honored with the highest office within the power of this organization, this position made more so by the splendid women who have been my predecessors. I am only going to ask that you give me the same loyal support and wholehearted cooperation that you have given in the past, and with this assurance there will be no doubt as to the year's success.

I wish for each and all of you the happiest of vacations. At our Board meeting in the early fall the program for the year will be outlined so that you may have an early start for the year's work. Be sure and read your Auxiliary page in the Journal every month. Remember I am glad to serve you and glad of the opportunity, and will say to each:

"Across the hours of silence
Across the miles of space
I stretch my hands in greetings,
And almost see your face."

Most sincerely yours,

Alice M. Harden.
(Mrs. Wyman W. Harden.)

Madame President and Members of Our Auxiliary:

I beg to submit the following report of the Fourteenth Annual Meeting of the Woman's Auxiliary to the American Medical Association, held in Kansas City, Missouri, May 11-15, 1936:

The Auxiliary held their sessions Tuesday and Wednesday mornings at the Baltimore Hotel in the Francis First Room—all the rooms are designated and decorated as such, the Charles 11th room and The Francis 1st. I attended the meet-

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★ *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
★★ *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
N. Y. State Jour. Med., Vol. 35, No. 11,590
Arch. Otolaryngology, March 1936, Vol. 23, No. 3, 306-309

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ings. On Tuesday morning Mrs. Rogers N. Herbert, President, a most attractive and capable woman, presided. The reports of the standing committees were heard. There was a gain in every department this year. There was much clear thinking and hard work on the part of all and the results achieved were excellent.

Here are some of the high-lights:

Hygeia—a gain of 1,575 subscriptions over last year. Mrs. James D. Lester, National Chairman, mentioned Florida as doing good work.

Organization—172 counties more than last year, with New York organized. Montana seems to be ready and they have their eyes on Connecticut and Rhode Island.

Program—Radio broadcasts were much appreciated all over the country. The program on Prenatal Care was particularly well received. Eight hundred expectant mothers wrote for that one paper. Any paper can be had for a dime, also all Hygeia articles can be reprinted.

Membership—Pennsylvania lead in membership.

The exhibits were splendid. Also the Archives and the Histories were compiled differently and showed lots of individuality.

Wednesday morning was the election of officers; also state reports. We noticed that no delegate had registered from Florida (in fact no woman from Florida was registered except myself) so I became your delegate. The state reports were similar, naturally working along the same lines but all seemed more interested in their work this year.

Now as for entertainment. They had a Southern Breakfast which was well attended at eight in the morning and many elaborate luncheons. At each the doctor who was the guest speaker, stressed the importance of Hygeia. At one of the affairs, a singer imitated birds better than I have ever heard it done, and I know that you will be pleased to hear that the mocking bird was given the most important place.

Hospitals were visited on Hospital Day; they were most modern and well equipped. And there was a lovely drive around the city Wednesday and a tea at Mrs. Robert's home. We also visited the Nelson Art Gallery which I think compares favorably with the Huntington Gallery of California.

Besides, I attended the opening session of the American Medical Association. It was interesting to hear Landon, the potential Presidential

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candidate address us, also to hear the beautiful tribute to President J. Tate Mason, our incoming American Medical Association President, although an air of sadness prevailed over the gathering because of his illness.

Mrs. Fitzgerald, our new Auxiliary President, has a most charming manner and I am sure that this year will be a most successful one.

The officers for the coming year are:

President—Mrs. Robert E. Fitzgerald, Wisconsin.

President-elect—Mrs. Augustus Peck, Pennsylvania.

First Vice-President—Mrs. David S. Long, Missouri.

Second Vice-President—Mrs. Prentiss Wilson, Washington, D. C.

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Fourth Vice-President—Mrs. Martin Norton, Minnesota.

Recording Secretary—Mrs. C. C. Tomlinson, Nebraska.

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Respectfuly submitted,

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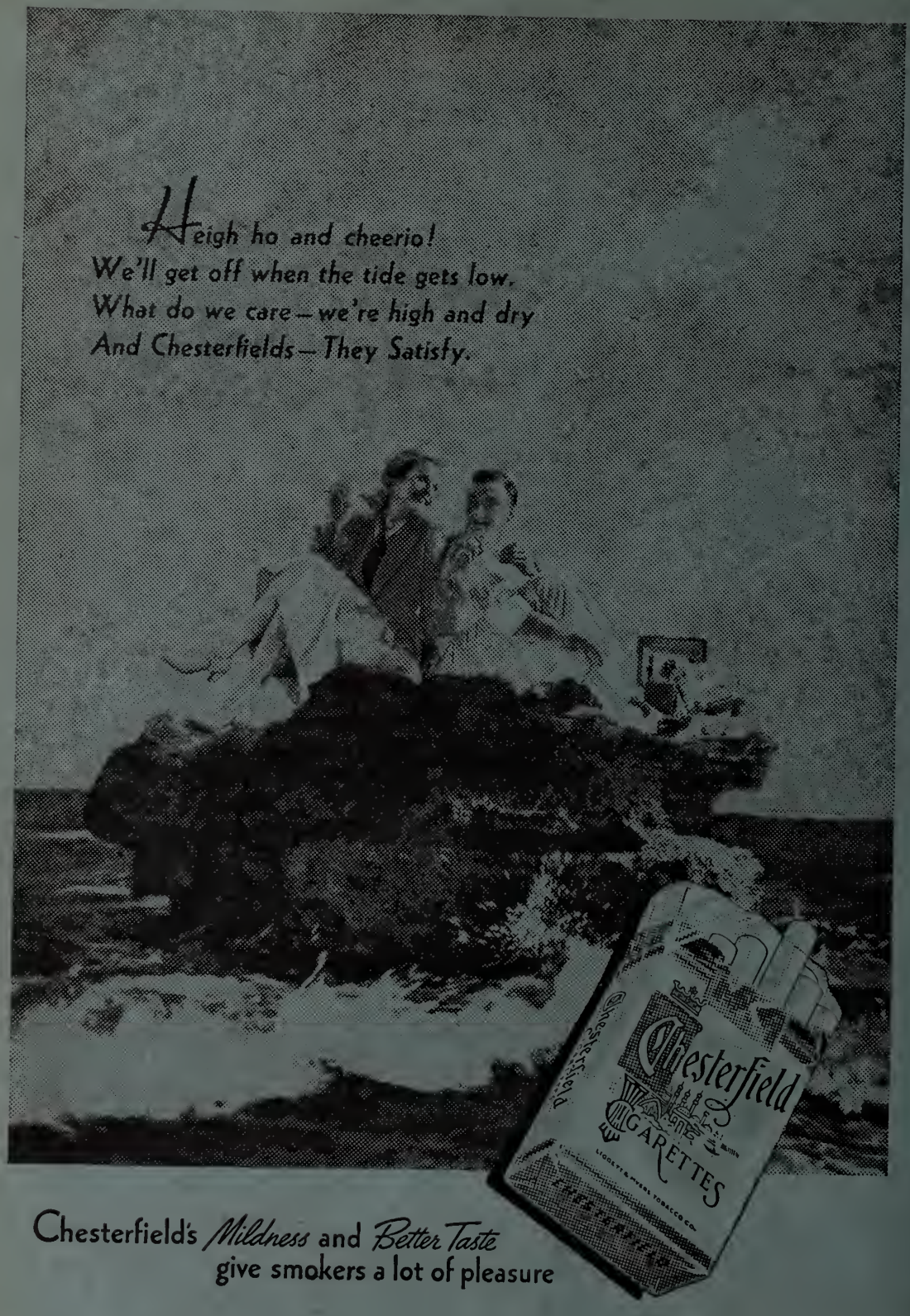
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	23	85%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			10	77%
Brevard	I. F. Bean, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	3	30%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	24	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	10	100%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg.. Miami	1st Friday 8:30 P.M.	Rod and Reel Club Hibiscus Island	194	87%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	12	60%
Duval	W. M. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	138	93%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	36	88%
Hillsborough	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	109	94%
Jackson	C. D. Whitaker, M.D., Dckle Bldg. Marianna	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	8	62%
Lake	R. H. Williams, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM..	Eustis	16	100%
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	33	97%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
Manatee	S. G. Hollingsworth, M. D. 451 12th. St. Bradenton	M. M. Harrison, M. D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	11	100%
Marion	J. N. Moore, M.D., 210-12 Professional Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	22	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	4	100%
Orange	William E. Sinclair, M. D. Clinic Bldg. Orlando	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies	56	100%
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	51	91%
Pasco-Hernando-Citrus	R. D.Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M.	Varies	11	85%
Pinellas	F.E. Kauffman, M.D Coachman Bldg., Clearwater	W. C. McConnell,, M. D. 1005 Equitable Bldg. St. Petersburg	1st. and 3rd. Friday 6:30 P.M.	Shrine Club St. Petersburg	81	100%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	49	83%
Putnam	Allen P. Gurganious, M. D. Palatka	A. E. Drexel, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Johns	Herbert E. White, M.D., 401 First Natl. Bank Bldg St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	9	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies	9	82%
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	15	94%
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	12	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies	4	100%
Taylor	J. C. Ellis, M.D., Perry	J. L. Weeks, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	5	83%
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Chowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies	35	92%
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies	6	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XXIII
NO. 2

Jacksonville, Florida, August, 1936

Yearly Subscription, $3.00
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THE NY ACADEMY OF MEDICINE
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American Medical Association, Atlantic City, 1937.
Southern Medical Association, Baltimore, Md., November 17-20, 1936.

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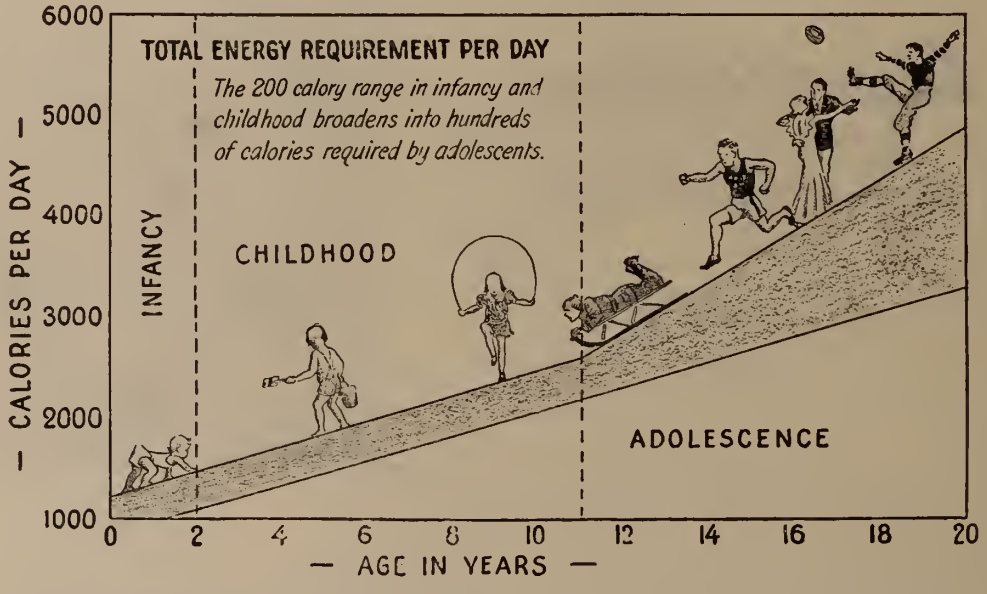
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*Martenstein, H.: Syphilis Treatment: Enquiry in Five Countries, *League of Nations Quart. Bull. Health Organ* 4:129, 1935.

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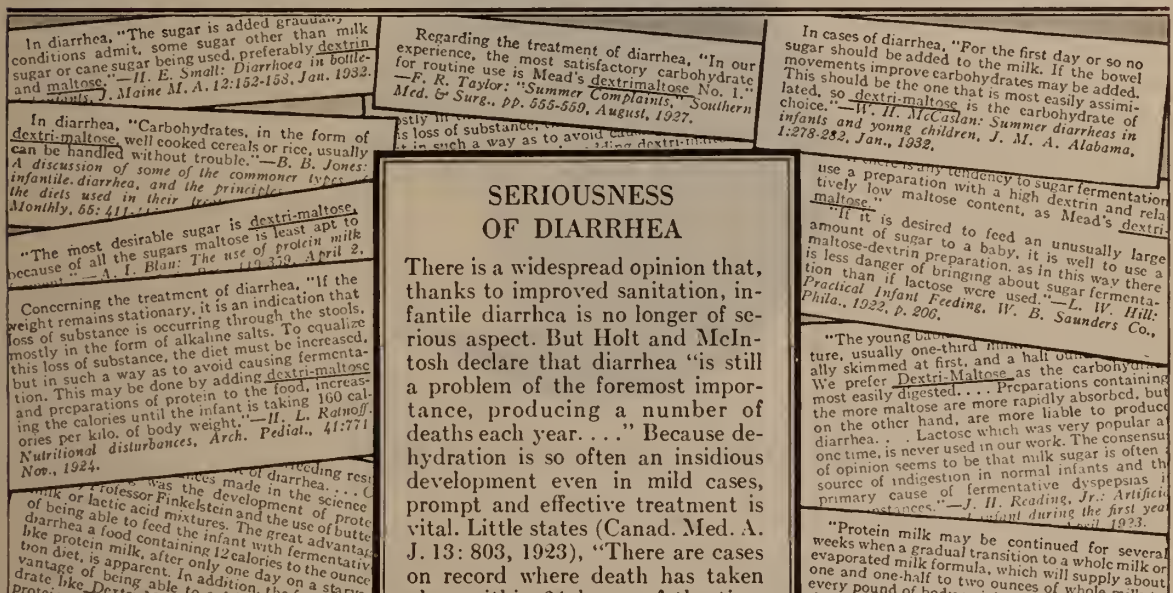


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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXIII | Jacksonville, Florida, August, 1936 | Number 2

INTRODUCTION TO SYMPOSIUM ON COLLAPSE THERAPY OF PULMONARY TUBERCULOSIS

The idea of presenting this symposium to the Florida Medical Association was born in the Duval County Hospital, Jacksonville, where Dr. J. Knox Simpson and Dr. Kenneth Morris, surgeons, Dr. W. McL. Shaw, roentgenologist, and Dr. Louie Limbaugh, internist, have functioned as a chest team for the past several years.

This team meets at the hospital each week when case histories are presented for consideration of the advisable form of treatment. The chest team discusses these problems in an informal way, studies the x-ray films and decides which cases are to be given bed rest in the hospital and which cases are to receive some form of collapse treatment, whether pneumothorax, phrenic nerve interruption or thoracoplasty.

COLLAPSE THERAPY OF PULMONARY TUBERCULOSIS*

LOUIE LIMBAUGH, M.D.,
Jacksonville.

There has been a deservedly keen interest taken in the subject of collapse therapy of pulmonary tuberculosis in the past few years. Exhaustive studies and encouraging results have been reported in medical literature. As experience increases, the indications for collapse therapy are more thoroughly understood.

The object of collapse therapy is to put the diseased lung at rest, thus facilitating the formation of scar tissue and healing of the active tuberculous disease. When successful, this eliminates constitutional symptoms by decreasing the amount of toxic absorption; lessens the chance of spread of the disease to the normal portions of the lung or to the other lung; markedly reduces the length of time in which the patient is incapacitated; and removes the danger of spread of the disease to contacts.

The value of collapse therapy is most outstanding when the procedure has accomplished the obliteration of a cavity. In fact, some workers limit the consideration of this treatment to cases presenting cavitation. Cavitation, per se, must be obliterated or collapse therapy has not accomplished the desired result. No tuberculous lung disease can be expected to become arrested as long as there is a cavity present. Any patient with a tuberculous cavity in the lung, even though essentially symptom-free, is a source of real and constant danger to others; and unless that cavity is closed he, sooner or later, will break down with disastrous spread of the disease within his own body. Collapse therapy, however, may arrest an active tuberculous process in a lung before the stage of demonstrable cavitation has been reached or before the contralateral lung has become involved.

The indications for collapse therapy are becoming more liberal as its advantages are better understood and appreciated. Some workers are as yet conservative in their views, and others are undoubtedly quite the opposite. The typical, so-called "ideal", case is one of chronic unilateral fibrocaseous tuberculosis with cavitation. Successful collapse therapy is practically all-advantageous under these conditions. The most urgent indication for artificial pneumothorax is profuse pulmonary hemorrhage. Care must be taken to ascertain which lung contains the bleeding vessel. We feel that extensive unilateral caseous tuberculosis of chronic type and without demonstrable cavitation should be given the benefits of collapse therapy. Patients with less extensive disease of the same type are closely observed and frequently x-rayed. If the disease does not present evidence of healing, collapse of the lung is promptly instituted with artificial pneumothorax before adhesions necessitate a more drastic from of surgical collapse.

It has been our policy to start collapse therapy on chronic extensive fibrocaseous tuberculosis, with or without demonstrable cavitation, although tuberculous disease exists in the contralateral lung. The lesion in the opposite lung usually shows healing as the treated lung and the general condition of the patient improves. Bilateral pneumothorax should be tried if the disease in the contralateral lung fails to improve. If the contralateral disease is of the acute pneumonic type that lung should be collapsed first, and the extensive but chronic type of infection in the other lung treated later.

Should acute pneumonic tuberculosis develop in the contralateral lung during the course of artificial pneumothorax therapy, bilateral or al-

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held aboard the SS. "Florida", April 27, 28 and 29, 1936.

ternating pneumothorax may be attempted. If the original pneumothorax has been maintained for a period of about two years, that lung may be allowed to expand as the other lung is being collapsed. Bilateral collapse may be attempted in those patients with extensive chronic fibrocaseous disease with cavitation in both lungs if the general condition of the patient is encouraging.

The adult type of tuberculosis occurring in childhood responds well to collapse therapy and such patients are offered a more favorable prognosis than when treated by "rest-cure" alone.

There are three principal procedures employed in collapse therapy of pulmonary tuberculosis. It is generally conceded that the one of first choice is artificial pneumothorax. Phrenic nerve interruption has its advantages and indications. Thoracoplasty is frequently invaluable. Improvement in technique with advancement in partial or selective thoracoplasty procedures has done much toward removing this operation from the classification of a "drastic procedure." It still may be resorted to because other measures have failed, but the results shown are very encouraging. Phrenic nerve interruption and thoracoplasty will be more fully discussed by the next essayist.

Artificial pneumothorax usually is attempted first when collapse therapy is decided upon.

If adhesions do not prevent, it is easily carried out with relatively little risk. The degree of collapse is under control, and may be regulated or discontinued at will. The most common complication is fluid in the pleural cavity of the collapsed lung. Small amounts of fluid are frequent and usually are absorbed. It may be aspirated, if the amount present is excessive, through the pneumothorax needle at the time of a refill. Persistent formation of fluid may force abandonment of the procedure. Satisfactory artificial pneumothorax should be maintained for a period of about four years. This time limit is variable, depending upon the problems presented by the individual case.

Pneumolysis may be the means of converting an unsatisfactory artificial pneumothorax into a successful collapse. Cavities are occasionally held open by string-like adhesions from the lung to the chest wall. These suspended cavities are often completely obliterated by intrapleural pneumolysis and the patient spared further surgical measures. Care must be taken in the selection of cases suitable for this operation. Broad adhesions generally contain lung tissue and should not be cut. They may stretch and become string-like under persistent pneumothorax pressure, however, and become amenable to pneumolysis at a subsequent time if, by this means, the walls of the cavity have not been approximated.

The decision as to whether or when to use collapse therapy in any case of pulmonary tuberculosis should be based on the cooperative and combined efforts of internist, surgeon, and roentgenologist. The hope of further reducing the mortality rate of this disease rests in the interest manifested by many workers in these three fields of medicine throughout the world.

THE SURGERY OF PULMONARY TUBERCULOSIS*

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Not over five years ago Edward Archibald wrote the following words: ". . . whereas the physician of yesterday would have considered it criminal to perform an operation on the thorax of a consumptive patient, the newest system of surgery devotes some forty-odd pages to the consideration of such operations." And this writer complained that his style was absurdly cramped by such a pittance of space. Surgery in the treatment of pulmonary tuberculosis has come to stay. Although slow to spread at first, tremendous progress has been made in this form of treatment in recent years. Yet the great majority of the profession today does not realize its therapeutic value.

Brehmer and Dettweiler were the first to advocate rest in bed and for many patients this still constitutes sufficient treatment. The great value of the hygenic treatment inaugurated by these men in the middle of the 19th century should always remind us that tuberculosis is primarily a constitutional disease with local manifestations and that the old formula of rest, fresh air and good food still holds good.

Most patients, however, who do not improve with conservative treatment may be greatly benefited by some form of collapse therapy. Also, it is not wise to wait too long before instituting treatment in patients with active pulmonary tuberculosis with or without cavities who do not

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held aboard the SS. "Florida", April 27, 28 and 29, 1936.



FIG. 1, CASE 1.—Patient ill five years. Enormous cavity occupies practically entire upper left lobe. Medium size cavity middle lobe. Pneumothorax unsuccessful because of adhesions.

show improvement under conservative treatment. The surgical treatment of pulmonary tuberculosis is based on the principles of rest, collapse and compression of tuberculous cavities. Surgical procedures also aim at the release of tension caused by adhesions.

The collapse therapy of tuberculosis in Duval County has practically been confined to the Duval County Hospital. Diseases of the chest present difficult problems. To avoid mistakes, all cases have been reviewed by a chest team composed of the internist, roentgenologist and surgeon. There are three principal methods of collapse therapy: (1) artificial pneumothorax, (2) phrenic exeresis, or simple crushing of the phrenic nerve, and (3) thoracoplasty. Our chest team considers artificial pneumothorax a medical procedure.



FIG. 2, CASE 1.—Complete thoracoplasty left chest. Four stages necessary. Patient up on exercise. Sputum negative. Sedimentation test normal.

Artificial pneumothorax is usually the procedure of choice. The value of this method is well recognized and it alone may bring about economic recovery in about forty per cent of cases. However, success with artificial pneumothorax depends in the majority of cases upon a free pleural cavity. Adhesions are often present which prevent collapse of the diseased portion of the lung. Complications such as pleural effusions and empyema may also threaten the patient's life. It is precisely at this point when pneumothorax fails and the patient's life is threatened that surgical procedures should be instituted. In a small per-



FIG. 3, CASE 2.—Cavities upper left lobe. Pneumothorax discontinued because of adhesions. No improvement with bed rest. No disease in lower lobe. Ideal case for partial thoracoplasty.

centage of cases the procedure of closed pneumolysis or the division of adhesions with a thoracoscope will allow the pneumothorax to be completed satisfactorily. Adhesions may be coagulated with this instrument, thereby preventing hemorrhage and making the procedure a comparatively safe one.

The simplest and safest surgical procedure is interruption of the phrenic nerve. This nerve receives branches from the 3rd, 4th and 5th cervical and one from the sympathetic. Its roots unite about one to two inches above the clavicle and from this point the nerve passes downward and medialward on the anterior scalenus muscle. Under local anesthesia it can easily be exposed

through a short incision in the neck. Simple cutting of the nerve was first proposed by Steurtz in 1911 but it was found that a section alone did not always completely paralyze the diaphragm. Sometimes fibers from the sixth and seventh cervical and the nerve to the subclavious muscle join the main trunk below the site of simple phrenicotomy. For this reason the operation of phrenic exeresis or evulsion of the nerve by pulling up from 2 to 12 inches of the distal portion may be necessary to obtain complete paralysis. Simple crushing of the nerve is effective in the majority of cases and should be used when a return of function of the diaphragm is desired. Interruption of the phrenic nerve paralyzes the diaphragm and is equivalent to the introduction of about 300 to 400 c.c. of air in the pleural cavity. It brings about a diminution of one-third to one-fourth lung volume by allowing the diaphragm to rise from one to three inches. The indications for interruption of the phrenic nerve are:

(1) As a curative measure for chronic, unilateral, lower lobe tuberculosis.

(2) Cases in which pneumothorax is indicated but cannot be induced because of adhesions to the lung.

(3) As a test for the patient's ability to stand thoracoplasty but chiefly to improve the patient's general condition and make him a safer operative risk.

(4) To control profuse or recurring hemoptysis when pneumothorax cannot be induced.

(5) As an adjunct to pneumothorax by reducing the residual cavity and lengthening the interval between refills. It also relaxes adhesions which prevent effective collapse.

(6) To control excessive cough and expectoration in the better lung. It brings about ease of expectoration and often considerable general improvement.

(7) Small thin-walled cavities in the apex may sometimes be closed by interruption of the phrenic nerve.

Early in the 19th century, James Carson experimented with artificial pneumothorax but it was not until 1882 when this method was put into practice by Forlanini that the value of rest and collapse of the lung by mechanical means was established. This epoch-making discovery opened the way for other methods of collapse. Quincke in 1888 and Spengler in 1890 perceived the next step and understood that the release of tension by resection of the ribs was necessary.



FIG. 4, CASE 2.—Partial thoracoplasty. Seven ribs removed in two stages. Lower lobe not collapsed and functioning well. Patient up. Sedimentation test normal. Sputum negative.

Brauer was the first to realize that extensive rib resection was necessary and in this work he was aided by Freidrich. But the Brauer-Friedrich operation was too extensive to be safe. So it was not until 1913 that the operation of thoracoplasty was placed on a safe basis by Sauerbruch.

Extra-pleural thoracoplasty as standardized by Sauerbruch consists in the extra-pleural resection of the posterior portion of the upper ten or eleven ribs in two or more stages. From two centimeters of the first rib to ten and eleven centimeters of the tenth and eleventh ribs are removed. The pleural cavity is not opened. The posterior portion of the ribs is fixed and forms the greatest part of the transverse diameter of the chest. When this part is removed the movable anterior portion readily collapses and the greatest amount of compression is obtained. The aim of this operation is to obtain rest of the lung and compression of its cavities. However, in recent years surgeons have begun to realize, as Davies puts it, "that the original stereotype operation inflicts an unnecessary collapse of healthy lung tissue in some cases and in others, especially those with large cavities, demands not only the relaxation of the walls but also their approximation." Cavities which do not respond to simpler measures are of grave danger to the patient and an arrest of the case cannot be effected unless these lesions are closed. The modern selective thoracoplasty aims at the complete removal of ribs overlying the cavity. If the operation is efficiently planned it is possible to oblit-

erate a very large and thick walled cavity. This may necessitate the complete removal of all the upper ribs including the transverse process of the vertebrae and parts of the costal cartileges. This procedure can be tolerated if done in a sufficient number of stages. Usually only two or three ribs are removed at the first operation. Three or more ribs may be removed at the second or third stage depending on the condition of the patient and the amount of collapse desired. Careful medical preparation, vital capacity tests and small transfusions preoperatively and between stages are factors which make for safety. Ethylene and nitrous oxide are the anesthesias of choice. More recently cyclo propane has been advocated as the ideal anesthetic for thoracoplasty.

Generally speaking, thoracoplasty is indicated in the following conditions:

(1) Unilateral fibro-ulcerative pulmonary tuberculosis where the other lung is healthy or healed and where no improvement can be shown under sanitarium treatment or simple methods of collapse therapy.

(2) Large unilateral cavities which do not respond to simple methods may be effectively collapsed by thoracoplasty.

(3) Tuberculous empyema when there is no tendency of the lung to expand following frequent aspirations. Without surgical treatment the prognosis for these patients is grave.

The resistance of the patient as evidenced by scar tissue is the most important consideration. Fibrosis with cavitation where there is shrinking and fixation of the lung present the ideal condition for permanent collapse.



FIG. 5, CASE 2.—Bronchography with Iodochlorol shows cavities have been obliterated. Note dead-end bronchi in collapsed portion of left lung.

Recently the indications for thoracoplasty have become more liberal. This is a natural result of improvement in technique, lowered mortality and a better understanding of its advantages. Some workers are as yet conservative in their views and others are undoubtedly quite the opposite. Certainly the cases should be carefully selected, the patients should show ability to help themselves and no patient should be subjected to a thoracoplasty who is not otherwise a good operative risk. To operate because one believes that the patient is going to die anyway only brings discredit to a valuable surgical procedure.

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MOVING PICTURE DEMONSTRATION OF X-RAY FILMS*

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Jacksonville.

My small contribution to this symposium will consist of demonstrating by the roentgen ray some of the good work that Drs. Morris and Limbaugh have been doing in this subject. It is not necessary to discuss with this audience the universally accepted fact of the importance of the x-ray examination in the diagnosis and treatment of chest diseases.

In gathering these data, it was discovered that the fine detail of lung structures could be caught

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held aboard the SS. "Florida", April 27, 28 and 29, 1936.

and transposed to the movie screen from the x-ray film just as well as, or even better than, on the conventional single lantern slide. Therefore, in order to demonstrate the continuity of effort and repair of diseased processes I have assembled for your consideration a group of nine cases in a moving picture film. We will demonstrate various periods of repair in six cases of pneumothorax, one being a bilateral pneumothorax; two cases of phrenico-exeresis and one case of selective thoracoplasty.

(The movie followed).

DISCUSSION

Dr. Frazier J. Payton, Miami Beach:

I wish first to compliment the essayists on the general excellence of their individual presentations and collectively on the excellence of the symposium. Secondly, I wish to call your attention to the fact that this excellence has been attained primarily by close and wholehearted cooperation between the internist, the surgeon and the roentgenologist. This is a splendid example of the possibilities when such cooperation is extant. This is a direct refutation of a statement made by one of the essayists at a recent meeting of the State Tuberculosis Association. I cannot permit it to go unchallenged.

THE CONTROL OF SYPHILIS*

With Special Emphasis on Adequate Treatment as a Control Measure.

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For a health officer who anticipates the potential attainments of a comprehensive program directed against syphilis, it is difficult to conceive why a wholehearted effort has not been launched by all health departments to bring this important problem to a solution. In the past, health departments have been prone to concentrate attention upon problems which relate particularly to the acute communicable diseases. This has been done presumably because such problems could be solved much more rapidly than those relating to an insidious disease such as syphilis. The efficiency of modern health organizations has made it possible to limit the spread of most of the acute communicable diseases, and now one of the first duties of the well organized health department is a serious attempt at the control of syphilis.

*Read before the Seventh Annual Meeting of the Florida Public Health Association, Orlando, Dec. 2, 3, 4, 1935.

ADMINISTRATION OF THE SYPHILIS CONTROL PROGRAM

The health department of any State, or large city, or district should include in its organization a full-time venereal disease control officer. This venereal disease control officer should be a medical graduate with adequate training. He should, preferably, have qualified as a health officer either in charge of a health unit or acting as an assistant, and should have had some training in the clinical management of syphilis and gonorrhea.

It is immaterial whether the venereal disease control section of the health department be under the immediate jurisdiction of the division of communicable disease control, or whether it be operated as a separate division. In any event, close cooperation should exist between the venereal disease control section, the communicable disease division, and the health department laboratory. Depending upon circumstances, one or more nurses for venereal disease control work should be available, as well as adequate secretarial assistance.

A most important point in the development of the venereal disease control program is the extension of financial support commensurate with the relative importance of the problem. This point has been brought indirectly to the attention of public health workers in a report of the Subcommittee on Current Practices of Health Departments of the Committee on Administrative Practice of the American Public Health Association. In this report the allocation of funds in representative city health departments throughout the United States is analyzed.[1] The expenditures of these cities for venereal disease control work averaged only one-twentieth of all funds allocated for the control of the communicable diseases in general. In spite of very inadequate morbidity reporting, venereal diseases have constituted during the past decade approximately one-fifth of all communicable diseases reported to State health departments and the United States Public Health Service by local health departments. The sums allocated for venereal disease control work in these cities, therefore, are, very obviously, not commensurate with the extent of the actual problem. Allocations made in many State and local health departments probably do not differ materially from the allotments discussed in the report.

It is not desired to insist arbitrarily that exactly 20 per cent of all funds available for com-

municable disease control work be devoted to the development of the venereal disease program, but it is a basic principle that sufficient funds be made available for the development of a comprehensive program. This problem is not merely a local one, but a nation-wide one which should receive alike the financial assistance and support of local, State, and Federal health authorities. Such monetary support should be general because of the great economic importance of syphilis and the fact that infected individuals in a communicable stage may, as the result of modern transportation, move freely from State to State while still infectious.

THE ADMINISTRATION OF ADEQUATE TREATMENT

There are two fundamental principles in the control of syphilis with which every health officer should be acquainted. The first and most important of these is the effectiveness of adequate treatment in the early stage of the disease. The second is the ease with which the prenatal transmission of syphilis may be prevented by proper treatment of the mother.

The prompt administration of adequate treatment in early syphilis is dependent upon early diagnosis. Early diagnosis is dependent upon the development of an inclusive laboratory service. Best results are attained when treatment is started in the primary stage of syphilis, before the serologic reaction has become positive. The necessity for providing one of the practical methods of darkfield examination for every physician who treats the disease is therefore obvious. It has been found in a large series of cases that if repeated darkfield examinations for *Spirochaeta pallida* are performed, the diagnosis may be made in 94 per cent of the cases in the seronegative primary stage. Secondary lesions involving the genitalia yield positive darkfield examinations in 91 per cent of the cases, while secondary lesions involving the mouth and throat are reported positive at some time during repeated examinations in 86 per cent of the cases. It is in the seronegative primary stage, however, that the darkfield assumes its greatest importance, since a diagnosis can easily be made in this way, whereas serologic methods fail. For these reasons, it is essential that State, large municipal, and district health departments provide for the diagnosis of syphilis by darkfield examination. If a thoroughly qualified darkfield technician is not available, as in small local health departments, the delayed darkfield method should be employed, specimens of chancre serum being collected in capillary tubes and forwarded to a central laboratory.

In a series of recent studies the Cooperative Clinical Group, together with the Public Health Service, has shown that satisfactory results may be attained by the administration of an adequate amount of continuous alternating antisyphilitic therapy in from 64 to 86 per cent of the cases of early syphilis. The best results were attained when treatment was instituted in seronegative primary syphilis. As used in these studies, the term "satisfactory result" implies that the patient had been followed for 2 years or more, and that during one probationary year he had no symptoms of syphilis, his blood had been consistently negative, he had a negative spinal fluid examination and a negative physical examination, or he had a reinfection.

Many fundamental principles in the mode of transmission of syphilis are at the present time not certainly known. Except for the probability of the syphilitic pregnant woman transmitting the disease to her offspring and the more remote possibility of transmission of syphilis to the marital partner in the latent stage through the semen, the first five years of the syphilitic infection constitute the most important period from the standpoint of public health control. Indeed, it is the opinion of workers in the epidemiology of syphilis that the vast majority of syphilitic infections are transmitted by the person who has syphilis of less than one year's duration.[2]

An analysis of the records of the five clinics included in the Cooperative Clinical Group indicates that the critical time for the adequate treatment of the syphilitic patient to prevent infectious relapse is the first two years.[3] It is to be noted that, without regard to the administration of treatment, 55 per cent of the cases of infectious relapse occurred within the first year of the syphilitic infection, and by the end of the second year 85 per cent of all cases of infectious relapse had occurred. The records of 3,244 cases of early syphilis treated in these clinics indicated that 8 out of every 10 patients who showed a communicable form of relapse had received less than 15 doses of arsphenamine with accompanying heavy metal. The inadequately treated patient, with his peculiar immunologic response, may be almost as grave a danger as the patient who has received no treatment whatever. The above statement should not be construed as an argument against the treatment of syphilis, however, since among cases under ob-

servation or treatment for six months or longer only 2.7 per cent of those patients receiving adequate antisyphilitic treatment suffered a communicable form of relapse as compared with 13.1 per cent of those patients who received treatment which was inadequate. When modern treatment for syphilis is started in the seronegative primary stage, the communicable lesions of secondary syphilis are prevented. The full prosecution of such adequate treatment to its ultimate termination will prevent all types of subsequent communicable relapse.

The prevention of the transmission of prenatal syphilis by proper treatment is a fact which has been incontestably proved. McCord[4] has been able to show that if treatment is started before the fifth month of pregnancy and 10 or more doses of one of the arsphenamines and accompanying heavy metal are given, an apparently healthy child may be expected at term in 95 per cent of the cases. The untreated latent syphilitic pregnant woman bears an apparently healthy child in only 17 per cent of the cases. The Cooperative Clinical Group has been able to confirm McCord's observations in a study of 603 syphilitic women who had undergone 922 pregnancies.[5] The results in 607 of these pregnancies were known, and when adequate antepartum treatment had been given an apparently normal child was born at term in 91 per cent of the cases.

The practicability of the control of syphilis by present-day methods is clearly demonstrated by the above facts. The question which next arises is the most practical administrative procedure to be pursued in extending treatment to infected individuals, particularly to those who cannot afford to pay for adequate treatment. In urban areas, hospitals to which polyclinics are attached should serve the best purpose in the organization of adequate treatment facilities. Such polyclinics have the advantage of receiving patients of all types so that the identity of the syphilitic individual is not made known. In addition, they offer consultative service of many kinds which may prove of untold value should complications develop. The subsidizing of polyclinics which meet minimum requirements of efficiency, in order that they may treat patients who cannot afford adequate treatment by a private physician, is a proper function of the health department.

In rural communities one or more of the following facilities may be organized for the administration of adequate treatment to indigent patients: (1) the development of syphilis clinics in county health units, administering antisyphilitic treatment in the same quarters in which general preventive measures are applied; (2) the subventionary assistance of properly qualified local physicians for the provision of prompt diagnosis and approved treatment; (3) subsidies for the transportation and treatment of infected patients to the nearest center at which proper treatment may be obtained; (4) the establishment of clinics in rural communities in which large numbers of Negroes are included in the population; and (5) possibly the development of a traveling health unit in which the necessary measures may be instituted for the prevention of all communicable diseases, including treatment of the venereal diseases.

In rural communities in the South, special arrangements are essential for the treatment of the Negro population. This racial group constitutes a most grave problem in syphilis control. Unless adequate treatment is given to all such groups, a reservoir will be maintained from which syphilis will be transmitted to the population at large and the general control program made ineffective.

CONCLUSIONS

1. In the organization of the venereal disease control program it is essential that a full-time venereal disease control officer be appointed in all large health departments.

2. A reliable laboratory service, including the provision of both darkfield examinations and serologic tests for syphilis, should be made available.

3. The fundamental therapeutic principles in the control of syphilis are: (a) adequate treatment for the early case as soon as possible after the development of the infection; and (b) proper treatment of the syphilitic pregnant woman, begun if possible before the fifth month of pregnancy.

4. Acceptable polyclinics in general hospitals should be subsidized in order that they may treat infected citizens who are unable to pay for treatment by a private physician.

5. In rural communities, the means whereby treatment is provided for syphilitic patients must vary with the conditions peculiar to the community.

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CHRONIC CERVICITIS*

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Inflammation of the cervix starts in the lining mucosa and is often referred to as "endocervicitis," but as the inflammation quickly involves the underlying deeper tissues of the cervix, "cervicitis" is the better term. Cervicitis includes also the accompanying secondary effects, such as eversion, erosion, and cystic changes.

Grossly, chronic cervicitis without laceration presents tenacious mucopurulent discharge in the canal, with slight enlargement of the cervix and usually some eversion and erosion. There may be considerable cystic change from inflammatory blocking of the gland ducts. If the cervix has been lacerated, there is great change in contour, with marked eversion and enlargement from infiltration and cyst formation. There may be erosion in various stages of healing. On cut surface cystic glands are seen along the canal and extending into the underlying muscle.

For an understanding of the complicated microscopic picture presented by chronic cervicitis with eversion, erosion, cyst formation, and the sequelae of laceration, one must keep in mind the two types of epithelium which meet here, and the way in which each reacts to varying irritation. In the adult, two types of epithelium meet at the external os. Normally the single-layered columnar epithelium is entirely within the cervical canal and thus protected from irritation, while the protective many-layered squamous epithelium entirely covers the vaginal portion of the cervix. There are two conditions in which columnar epithelium becomes exposed to irritation of the vaginal contents, namely, eversion and erosion. In eversion there is a turning out of the columnar-lined intra-cervical mucosa, due to laceration of the cervix or to swelling from inflammation. Inflammatory infiltration alone may cause the mucosa to widen the external os and evert, so that it appears as a reddened area. In eversion there is no encroachment of one type of epithelium in the field of the other, there is simply a turning out of the intracervical tissue, the old external os still marking the point where it meets the normal squamous epithelium. In erosion of the cervix, the lining squamous epithelium has been displaced, usually by inflammation; the columnar epithelium of the intracervical canal tends to multiply and cover the portion formerly covered by the displaced squamous epithelium.

The natural process for repair is for the squamous epithelium to gradually reform and grow in from the edges of the eroded tissue, thus replacing the columnar epithelium. Unfortunately, such a spontaneous natural repair is very rare. During the replacement of the squamous epithelium by the columnar epithelium, there is a tendency for the columnar epithelium to penetrate into the underlying mucosal tissue with the formation of glandular-like tissue, or the secretion of the glandular cells may be blocked off with squamous tissue with the resultant formation of small (Nabothian) cysts. Sections of this tissue by an inexperienced pathologist may lead to an erroneous diagnosis of the various forms of malignancies which are found in the cervix. However, one must bear in mind that the relationship between a cervicitis, laceration of the cervix and carcinoma is well established. The laceration furnishes soil for infection; the cervicitis and eversion follow. The abnormal cell changes that so frequently follow Nature's repeated attempts at repair are but a step from the disorderly arrangement which occurs when a true malignancy is found. All authorities agree that the most important prophylactic treatment of a carcinoma of the cervix is an early cure of the lacerated infected cervix. No time should be wasted watching chronic cervicitis for the evidence of a cancer.

The principal symptom of a chronic cervicitis is a chronic mucopurulent discharge. Associated with this, but usually and principally due to the accompanying lesions (lacerated perineum, uterine and adnexal inflammation), there may be a sense of weight and dragging in the pelvis and backache. The uterine and adnexal inflammation being secondary to the cervical condition and being due to an extension through the lymphatics of the broad ligament, causes a metritis, parametritis, perisalpingitis, oophoritis or even a low grade pelvic peritonitis. The backache is usually caused by an extension from the cervix into the uterosacral lymphatics causing a thickening and tenderness in the uterosacral ligaments. Sterility is another important symptom of cervicitis in that the abnormal thick cervical secretion is a barrier to the ascent of the sperm. One may

*Read before the Regular Monthly Meeting of the Orange County Medical Society, Orlando, November 20, 1935.

frequently observe that the patient will promptly become pregnant after the infection in the cervix has been removed. The chronic cervix as a foci of infection has aptly been named the "pelvic tonsil." I do not believe any physical examination of the adult female is complete until possible cervical pathology has been definitely ruled out.

The diagnosis of cervicitis can readily be made by a careful pelvic examination including a good exposure of the cervix. Chronic cervicitis must be distinguished in the first place from inflammation or other lesion higher in the uterus or adnexa. There is a tendency to concentrate attention on an obvious lesion which can be seen through the speculum and miss higher lesions. In the vast majority of instances, a complaint of pelvic pain and disability is an indication of some disturbance in addition to the cervicitis and careful search should be made accordingly. As to the local condition in the cervix, the appearance and palpable findings of chronic cervicitis are so characteristic that there is little trouble in making a diagnosis. The principal diagnostic difficulty in chronic cervicitis is the question as to whether there is a beginning malignant formation.

In any treatment for chronic cervicitis with erosion, eversion or laceration, one must bear in mind the histopathology of the condition, that is the mal-arrangement of the columnar and squamous epithelium. Whatever line of treatment is adopted, the hoped for success will not be reached until the pathology is corrected and the underlying and superficial tissues are restored to their normal arrangements and cell layers.

As was discussed in the histopathology, it is not the erosion, eversion or laceration, but the accompanying infection which is the main factor in causing the symptomatology. Therefore any treatment which will either permanently or temporarily relieve cervicitis must be directed to remove the present infection.

Among the various plans of treatment are (1) the various chemical applications with or without tamponage (2) electrical cauterizations (3) coagulations (4) radium (5) surgical and last but not least the Crossen conization with the cutting electrode.

The various forms of chemical applications have proven unsatisfactory because the deeper seated infections cannot be reached by topical applications and also because of possible irritation to the vaginal mucosa. Electrical cauterizations, while of definite value, have the disadvantage of requiring from two to four or more visits, and the definite probability of scar tissue formation with a varying degree of stenosis of the cervical canal. Coagulations are unsatisfactory because there is no definite way to control the depth of the coagulation and the adage is to remember that it is better to undercoagulate than to overcoagulate. Then there is to be remembered that quite an extensive slough takes place along with an absorption of toxic by-products from a coagulation of the cervix. I have seen three cases of pelvic abscess resulting from coagulation of the cervix. Radium should be the last to be considered in the treatment of cervicitis because of the possible effect on the ovaries. The Sturmdorf has its disadvantage because of the length of hospital stay and here again the marked possibility of stenosis of the cervix.

The writer had the opportunity of seeing the present modification of the Crossen loop worked out from its infancy and observing the technic and after results for nearly five weeks. It was developed and first used by Dr. J. R. Crossen of Washington University Medical School in St. Louis at the Barnes Hospital, in May and June of 1934. The technic is the same as is used in the Hyams loop, but has the distinct advantage over the Hyams loop of accomplishing in one revolution what would take many revolutions for the Hyams loop. The essential difference between the Hyams and the Crossen loop is that the Crossen loop is a triangular electrode so arranged that the base will cone out the pathology at the external os and the lower portion of the cervical canal. The loop comes in three sizes, small, medium and large, and the loop suited to each particular case can be selected accordingly. The cervix is exposed and sterilized, the electrode tip is placed in the cervical canal, the current set on with the foot switch and the electrode slipped in the cervix until the base wire is just outside the cervix. The loop is then quickly rotated, the tissue is cut and the loop removed. If the current is adjusted properly, no effort is required to revolve the handle, the loop cutting with the same ease as a hot knife through butter. The operation with the Crossen loop requires less than one minute and gives a cleanly coned out operative field. It is very unusual for any free bleeding to occur and rarely, if ever, are sutures required. Any oozing in spots can be quickly stopped by either switching the endotherm machine to coagulation and touching the bleeding areas or by a wick tape touched in Monsell's

solution and left lightly packed in the cervix. It is quite easy to cone out old lacerations and the deeply infected glands. After the tissue is coned out, the cervical canal can be inspected and additional tissue removed if necessary. If the conization is properly done and the current is not too hot, very little scar tissue is encountered and certainly not the amount to be expected that would either cause a partial or complete stenosis of the cervical canal. I personally dilate the cervix to about twice its size before conization. I feel that in this way the infected tissue is packed together, the extra edema is pushed out of the tissue and there is not the danger of taking out more than the desired amount of normal tissue at the base of the infected tissue. Other advantages of the conization method besides the assurance of getting the diseased tissue and the reduced amount of cicatricial tissue postoperative are: it is an ideal method of removing tissue for biopsy; the hospitalization is from 36 to 72 hours; there is very little blood loss, if any, and no shock to the patient. I have observed over two hundred of these cases all the way from operation through the various stages of healing. Ordinarily the slough has completely gone in from seven to ten days leaving a clean non-irritated cervix. The cervix at the end of three weeks presents the clean regular appearance of the nulliparous cervix.

Since August of 1934, a total of 62 patients have undergone operation in the Orange General Hospital by the conization method. The preoperative diagnosis in these cases was as follows: chronic cervicitis 42; cancer of the cervix 1; possible cancer of the cervix (biopsy) 1; lacerated cervix with cystic degeneration 1; stricture of the cervix 1; stellate laceration of the cervix 1; eversion of the cervix 12; granular endometritis with cysts in cervical canal 1; endocervicitis with polyps 1; polyp growing from uterine cervix 1.

I am quite enthusiastic over the results I have obtained in my cases and I am sure the rest of the men here using this technic have obtained satisfactory results. I personally feel that the Crossen loop has offered to the field of gynecology in the treatment of these cervical conditions what the transurethral electrode has to the urologist in the prostatic resections.

REFERENCE

Crossen and Crossen: Diseases of Women. Eighth Edition, Chapter Eight.

ENDOMETRIOSIS*

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My interest in this subject was aroused by two instances of aberrant endometrial growth several years back. The first example occurred in the following case:

A white girl, M. B., age 20, first consulted me in the spring of 1928 complaining of abdominal distress. The symptoms and findings proved the source of trouble to be in the fallopian tubes, a typical case of acute salpingitis. After about six months of palliative treatment, a laparotomy was done. Both tubes and a wedge segment of the uterus were removed. A gutta percha drain was used for drainage. Soon afterwards a bluish red lesion became apparent at the site of the drain. No particular attention was paid to it until the time of the first postoperative menstruation, when I was quite surprised to find a few drops of blood exuding from the bluish area. The occurrence was repeated monthly for seven months after which it failed to continue. A regular monthly cycle in deepness of color was observed. There has been no recurrence and the patient is now in very good health.

The second example was one of the more frequent type:

In May, 1923, a white girl, age 22, was seen, who complained of menstrual distress, nervousness, pain and soreness in the pelvis. There was nothing to be found in the history, particularly no story of instrumentation of the uterus. Examination gave the following findings: The uterus was moderately retro-displaced. A mass was palpable in the region of the right adnexa, which, from the location, size, and feel, was thought to be an ovarian cyst. At operation the ovarian tumor was noted to be a chocolate cyst with typical tarry contents. In addition a dense mass of adhesions was found. The character of the adhesions was rather striking being exceedingly dense and rigid, looking very much like a malignant invasion of the greater part of the pelvis. Pathological reports confirmed a diagnosis of endometriosis. The cyst was removed together with several smaller ones of the other ovary and the wound closed without attempting radical removal as this procedure seemed too formidable to be justified. The young lady made an uneventful recovery and is quite well today.

*Read before the Florida East Coast Medical Association, St. Augustine, Nov. 1, 2, 1935.

Of interest from an endocrine standpoint was the occurrence of breast hardening each menstrual period for the past year and a half. Since her marriage some six months ago these periodic changes have ceased.

BRIEF RESUME OF ENDOMETRIOSIS

Observers have noted several etiological factors and it is quite likely that the mechanism varies in different cases.

(1) Retrograde menstruation may occur. Menstrual blood has been noted exuding from the fimbriated ends of the tubes during laparotomy at the time of menstruation. The frequent occurrence of retrodisplacement is probably an important factor in causing such retrograde menstrual flow.

(2) Backward flow of mentrual blood (containing epithelial fragments either from the uterus or the tubes) may be the result of instrumentation such as curettage and dilatation, radium therapy, and bi-manual examination.

(3) Probably endometrium at times invades directly the uterine muscles causing benign adenomyomata and is comparable to extension of carcinoma.

(4) There is evidence to support the theory that these tissue transplants may be carried through the veins and lymphatics.

(5) Embryonic rests of epithelial tissue may occur but will not be discussed here.

These etiological factors really explain only the mechanical extension of endometrium, and it is quite obvious that the extension may proceed through either of the several routes.

There is most certainly an endocrine abnormality underlying these changes in usual endometrial behavior. In a total of 111 cases of endometriosis, evidence of follicular over-activity has been observed.

A brief review of ovarian hormone activity may not be amiss here, in order to refresh your minds in this field. Those of us who were privileged to hear Dr. Novak this summer were deeply impressed with the importance of the endocrines in determination and treatment of many female disorders.

The follicular hormone known as folliculin, theelin, etc., develops from a growing graafian follicle. A number of such follicles develop at the start of menstruation but one predominates and gives rise to the hormone.

Development of the endometrium in the first place is dependent upon this hormone.

When ovulation occurs with rupture of the follicle and subsequent development of a corpus luteum in its place, a second hormone makes its appearance. As rupture occurs about the middle of the menstrual cycle, the second hormone acts only during the last two weeks and produces a secreting surface on the endometrium. The follicular hormone continues to act until the next menstruation at which time a sudden cessation of production of the hormone withdraws the activation source and the endometrium disintegrates and menstruation follows. If the ovum is fertilized, the hormone activity continues and the endometrium becomes decidua.

Many forms of the so-called "endometritis" are now known to be caused by prolonged or abnormal stimulation from the follicular hormone which in many instances fails to rupture, resulting in loss of the ripening effect of the corpus luteum hormone. This factor, then, is one to be considered the causation of endometrial migrations. Certainly it is true that an interruption in the production of theelin results in atrophy of the endometriomata and gradual cessation of the symptoms therefrom.

At present we may produce such a cessation by radiation or removal of the ovaries. There is a likelihood that with hormonal therapy we will later be able to discourage endometrial proliferation.

I might mention here that while we have been regaled with the enormous possibilities in curative and palliative treatment by use of the various female hormones, much is left to be desired. Dr. Novak in an editorial in the A. M. A. Journal remarks: "All in all, therefore, no great hardship would be worked on the female sex if ovarian organotherapy were suddenly blotted out."

The pathology may be briefly summarized:

(1) Retrodisplacements of the uterus are frequent contributing causes.

(2) Fibroids are often associated, and some such tumors may be caused by direct endometrial invasion of the muscle of the uterus.

(3) Chocolate cysts are often present, caused by tubal or uterine epithelial transplants. These cysts enlarge with each menstruation until the process subsides or rupture occurs, which is the typical result.

(4) Adhesions are almost pathognomic in their dense, rigid appearance. They are often caused

secondarily from rupture of a chocolate cyst with the spilling of the contents into the pelvis.

(5) Endometriomata (including adenomyomata) are characteristic features and occur in the bladder, recto-vaginal septum, uterus, abdominal scars and other locations.

The symptomatology and diagnosis need no further comment.

The treatment varies with size, location, age and general condition of the patient.

The choice is between:

(A) Radical removal, which should be preferred in young women or cases where the execution is not too hazardous, and

(B) Castration by surgery or radiation.

MEDICAL DAYS WITH LEGAL SHADOWS*

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From the day that the medical student receives his diploma and his right by examination and a license to practice the healing art, he is confronted with many tedious medical perplexities which involve each long day of his practice and always there is lurking in the shadows the legal entanglements in which he may become involved if this day's work is not properly conducted. Suffice it to say that there is no subject of more importance to the practicing physician than jurisprudence and probably none which is so neglected in his learning.

We would like to interpret medical jurisprudence as that branch of science which shows how the law affects the practice of medicine and we hope that it may be illustrated in a practical way. It matters not whether a physician is specializing or in general, group or institutional practice, the fact remains that he is constantly confronted with matters involving legal technicalities with which he should be at least abstractly familiar.

Certainly the man who from dawn to dawn is contacting and caring for the sick and injured has very little time for thought relative to whether the procedure he is performing may or may not have a legal consideration. However, when we look at the Journal of the American Medical Association of November 2, 1935, page 1460, under "Medicolegal," we find the following captions:

"Malpractice: Medical Books as Evidence; Expert Testimony." This tells of a case in which the plaintiff suffered a fracture dislocation of the left ankle (Pott's Fracture) and was treated by physician defendant. The patient became dissatisfied and consulted other physicians. He then sued and won a decision. The case was appealed to the Supreme Court where the defendant was granted a new trial because of the fact that it is error to admit medical books as evidence because: "A medical work may be standard this year and obsolete next. The opinion of the same author changes in the different editions, owing to new discoveries and a better understanding of symptoms. The very best works, aside from observations, are largely made up of the opinions either of the author or of others compiled. It is a well-known fact that physicians after research and investigation often differ radically."

(2) "Silicosis: Liability of Employer under Common Law." The plaintiff, employee of the defendant company, developed, through the inhalation of dust and other impurities in the factory, silicosis. He claimed compensation, but the industrial board dismissed the case under the workman's compensation act of New York, thereupon he sued the defendant at common law. In spite of the definition of "injury" by the act the Court held that silicosis is an occupational disease due to "something catastrophic or extraordinary," and the Court of Appeals held that complaint stated facts sufficient to constitute a cause of action.

(3) "Malpractice: Indemnity Insurance. Insurer required to pay insured physician's traveling expenses incident to his attendance at trial."

(4) "Practice of Medicine: License not revocable for unauthorized acts of unlicensed assistant."

(5) "Medical Practice Acts: Conviction of crime involving moral turpitude as ground for revocation of license."

(6) "Malpractice: Gauze pack intentionally left in abdomen."

The A. M. A. Journal of October 26, 1935, sets forth the following cases:

(1) "Malpractice: Needle left in abdomen. Physician defendant in performing appendectomy testified he used only curved needles; but

*Read before the Florida East Coast Medical Association, St. Augustine, Nov. 1, 2, 1935.

the patient testified that he had never swallowed a needle and the attending physician testified that he had surgically removed a straight needle from the psoas muscle three and one-half months after the operation. The court assuming the testimony true, then the needle must have arrived in the patient's abdomen through inadvertence and without any actual knowledge on the part of anyone, but since the nurse's tray carried a needle during operation like the one removed, the jury concluded that it must have entered during the operation and the plaintiff patient was awarded the verdict."

From the Journal of October 12, 1935, we quote:

(1) "Alcoholism: Intoxication Defined. Mississippi—There are degrees of intoxication varying all the way from slight stimulation to complete coma. It is only at some point along the line between the two extremes that the loss of control of the mental faculties occurs. In order for a person to be intoxicated, it is not necessary for him to be so much under the influence as to be mentally and physically incapable of taking care of himself. Minnesota—When a person is so affected by intoxicating liquor as not to possess that clearness of intellect and control of himself that he otherwise would have, he is under the influence of intoxicating liquor."

(2) "Malpractice: Burn following application of diathermy."

(3) "Malpractice: Standard of skill and care required of specialist; necessity for expert testimony."

(4) "Malpractice: Care and skill required."

And from the Journal of October 5, 1935:

(1) "Malpractice: Piece of broken tonsillotome blade in patient's body; statute of limitations."

(2) "Compensation of Physicians: Patient's wealth a factor in determining physician's fee."

(3) "Compensation of Physicians: Patient's wealth not a factor in determining of reasonable medical fee."

This recital of the titles and the occasional summary from the last five issues of the Journal of the American Medical Association, have been given you because we realize that similar cases are constantly confronting both the medical and the legal professions. In considering and examining the relationship which exists between the medical profession and the legal profession, it is well to consider that the legal profession invades and has constant contact with the field of all occupations, and that the legal profession in dealing with facts and circumstances medical in origin, does so no more frequently than it does with cases arising out of other occupations. Many doctors regard the legal profession with apprehension, but a fair examination of it will disclose that a competent and attentive doctor has nothing to fear.

The medical practitioner, dealing as he does with elements so dear to the individual as his comfort, safety, and even his life, is doubly exposed when accused of shortcomings. The accusations, and the liability arising therefrom, are much more serious in their import when directed at a medical man that at the member of any other profession.

When such accusations are made, they fall on much more receptive ears.

The subject of medical jurisprudence covers in itself a very broad field and at the outset we must remember that any lecture on such a subject must be general in nature. It is merely informative and is not advisory. The contents of this lecture have not been collected for the purpose of guiding a true course for the members of the medical profession but, on the contrary, were collected for the purpose of informing the members of the profession of certain pitfalls and dangers which exist in our practice with the hope that the members will thoroughly acquaint themselves with these elements most frequently encountered.

It is only natural that in such a field specific instances are too numerous to consider and in order to accomplish the purpose of this lecture we must necessarily confine ourselves to broad general principles.

One of the first principles by which we should guide ourselves and probably the best advice that you can acquire from a paper of this sort is this: If a problem arises frequently in your practice and you are not familiar with either your rights or liabilities arising out of the same, consult a competent attorney and follow his advice. This is sound practice inasmuch as facts alter every case and every rule of law and no general principle could adequately determine your course of conduct when liability either civilly or criminally is at stake. It is paradoxical that the first lesson and the first instruction given students of commercial law to apply in their businesses is the above advice. When in trouble, get a lawyer

and do not try to muddle through on what you think you know. Liability can be magnified greatly by a casual remark or admission growing out of a clumsy attempt to explain away a situation, whether it be serious or trivial.

Medical jurisprudence as it affects the medical profession can be principally divided into three parts:

1. Physicians' liability for their own acts.
2. Physicians' liability for acts done or performed by others while in their employ or under their supervision.
3. Physicians' civil or criminal responsibility.

We can easily assume that the average practitioner is less apprehensive of liability being placed on him for his own negligence or acts than he is about the liability and acts performed under his supervision or by his directions. It is only natural that one has sufficient confidence in his own ability to believe that he will faithfully perform his duties and adequately discharge them and does not particularly fear their results. He is more alarmed by the liability placed on him by the law for acts and duties performed by others under his supervision because it is obvious that he cannot be present for all of the ministrations to the patient. Consequently, our greatest concern is with the latter subject.

However, before we dispose of the question of a practitioner's liability for his own acts it is well to consider what general requirements the law expects of a practitioner in the discharge of his own duties.

PHYSICIAN'S OWN TORTS

Contrary to the general belief among laymen and to some degree among members of our own profession, a doctor is placed under no necessity by the law to accept any case that he does not care to accept, regardless of the circumstances. The beginning of a doctor's responsibility to a patient and, of course, any liability resulting from the same, is based upon a contract between the parties. No doctor is compelled to make a contract with any one. This has been the rule of law most generally accepted in the United States and has even been upheld in cases where immediate attention is necessary for the preservation of life. However, it is well to consider that the general trend in this country is away from this principle and that there is an exception arising in the case of emergency when emergency measures are necessary for the preservation of life. The Courts are beginning to turn, at least in theory if not in actual holdings, to the principle that, because of a doctor's oath and his position in society and the representation which he makes, that he is necessarily compelled to attend patients when they are before him who are in need of immediate attention to save their lives. That, however, is merely a trend of thought slowly developing in our Courts. Probably it would not be extended to cover the case of an emergency call by telephone so it is obvious that regardless of this exception just referred to that a contract is the basis on which our medical practice rests.

Liability enters the practice only when there has been some flagrant violation of a contract. What then will violate your contract and make you liable for your own acts? Negligence alone will do this. Negligence naturally does not mean that merely because you do not cure a patient that you become liable, because it is impliedly understood between the parties that you will do only what you are able to do and deem necessary to do in the way of treatment, and the results are no criterion of liability or of successful administration. Negligence, then, arises only under the question of what you did or how you did it or whether you exceeded the instructions given you by the patient or exceeded the terms of the agreement between you and the patient. Then two factors should be carefully considered in our relations with our patients. In the first, what determines the required necessary amount of knowledge, skill and care that you should give the patient? This has been answered by the Courts to mean that the knowledge and skill and care which a practitioner owes to his patient as a result of their contract, is the average knowledge, skill, and care practiced in the community in which the doctor practices. We can see, therefore, that a doctor is not held up to a degree of knowledge, skill, and care practiced in another community or another country and is not required to blindly accept new and probably untried developments that emerge from foreign clinics or our own hospitals or medical schools. In passing, we might observe that very few cases arise in our Courts from lack of knowledge and skill unless they are born of flagrant quackery. The average practitioner is neither held up to the knowledge and skill of specialists in the community in which he practices. This is the least alarming feature of a doctor's liability and for every case arising from this act of negligence,

there are at least ten arising from lack of care alone so that the practitioner can easily see that his problem in his own practice rests on his own shoulders more because of the attention and care required than upon his knowledge and skill. A further discussion of this branch of medical jurisprudence is hardly necessary.

Another element entering this particular field, however, is that of emergency measures arising during treatment of a patient. Steps to consider when you proceed to take emergency measures during the treatment of a patient, depend on the objective of the treatment and the implied consent of the patient for such emergency steps because the objective in the treatment of a patient is the correction of defects and conditions to bring about a cure or improvement in the patient. Any emergency steps may be taken based on an implied consent if not the actual consent of the patient for such steps. But this is confined within the bounds of reason, and emergency steps of even a minor nature must be based on not only the doctor's best judgment, but must meet the standard of his fellow practitioners in his community as to reasonableness. In other words, the doctor's best judgment should also be reasonable judgment as interpreted by the practice in his own community. More serious emergency measures can be undertaken only on one theory, namely: that they are necessary for the preservation of life and anything that is essential and necessary for the preservation of life is permissible; however, it is always advisable to have a consultation with other physicians when possible, if only for a protective purpose.

It has been held, further, that emergency measures undertaken without the expressed consent of the patient, or his legal representative, when the physician deems that an unattended condition might possibly bring death is not a sufficient justification for such steps without the consent of the patient, but rather the condition must be of such serious nature that it not only might possibly result in death but probably will result in death. This question most frequently arises in cases of amputations and our profession must be constantly alert to the dangers in such cases and protect themselves as much as possible by securing consultations with other physicians or securing the expressed consent of the patient.

LIABILITY OF PHYSICIANS FOR NEGLIGENT ACTS OF OTHERS

We come now to the subject of liability imposed by law upon a physician for the negligent acts of others whom he employs or supervises in their work, which subject is one of increasing interest to the medical profession. This branch of the law is increasing in importance because of the increasing use of technicians and other agents in the practice of medicine. The trend in medicine today, apparently, is towards the employment of assistants, agents, nurses, technicians and specialists by the general practitioner after he begins a course of treatment on the patient founded upon an original contract with the patient. The rule of law in the case of agents is that the master is liable in damages for the negligence of his servants or agents within the scope of their delegated powers and agency. That means then that one whom you have instructed to attend to the care or demands of a patient, and who does so negligently, will make the physician so employing that agent liable for the negligent act. Many physicians are learning this to their sorrow, believing that they can be held liable only for their own negligent acts, but an examination of the late cases in the United States shows that as many doctors have been found liable through law or agency as have been through their own negligence. It is apparent that the profession must be extremely careful in this field. There are several ways of avoiding this type of liability. The first is not to represent the patient in the securing of nurses, technicians or other agents but to act only as an intermediary by way of suggesting available persons suitable for the type of work demanded. This will avoid liability; however, it is often necessary to secure assistance without first consulting the patient as to the person or persons wanted. This is hazardous business at best and it is extremely important that a competent and capable person be employed. Another hazard which confronts the practitioner is the giving of instructions to others engaged on a case. For example, should a physician instruct a nurse to perform a certain duty which is connected with the practice of medicine more than with the practice of nursing, such act, if performed negligently, would result in liability falling upon the doctor if the nurse has been retained under contract with the patient with the purpose of only nursing and not giving medical attention, and the doctor, by instructing the nurse to perform some medical task, has made that nurse his agent and any negligence she is guilty of, falls upon the shoulders of the doctor.

This field as you can see from the above is one that can never require too much attention on the part of the practitioner for within this field can occur more negligent acts, resulting in liability to the doctor, than is possible in almost any other branch of the profession. It is extended by the law to include those doctors called into the case by the first attending physician, and making him liable for the negligent acts of the other physicians, who are considered by the law as assisting him, rather than the patient. As pointed out before, if the attending physician had persuaded the patient that it was advisable to call in a certain specialist and the patient had made a separate contract of employment with the specialist, then the specialist alone would be liable for his own negligence, but, if the attending physician calls in a specialist to collaborate with him, then the attending physician is liable for the specialist's negligence. This principle is extended throughout the entire field above described.

PHYSICIANS AND CRIMINAL RESPONSIBILITY

The third and last subject to be covered in this lecture is that of criminal responsibility of physicians. There are a number of other phases of the medical practice which are of importance but are not of such importance as to require the necessity of mention in this paper. Some of them have to do with the enforcement of contracts and payment and others concerning property rights. None of these are any more attributable to the medical profession than any other profession and the problems arising from the same are solved by general rules of law which are applicable to all business transactions. The third division which is peculiar to the practice of medicine, and which has not yet been covered in this paper, is that of criminal negligence. This branch of medical liability can be divided into two classes: one, crminal negligence which arises usually from an act of omission rather than commission and second, the distinct crime arising from an act of commission. The first mentioned, namely, criminal negligence, is based on the gross negligence or carelessness of a physician. The majority of cases coming under this head are those resulting in death from wanton and willful acts of a physician. It is obvious to all what should constitute the negligence necessary for a conviction in this class of case. When negligence is so gross as to qualify under the term of willful or wanton, or both, then a case of malpractice for which civil liability would lie, becomes a case where the physician is liable criminally. Naturally, cases in this category are very few and should require no further discussion. However, there are a number of cases involving the subject of false imprisonment which the legal profession should acquaint themselves with, as this form of criminal responsibility is extremely important to the practitioner. It arises usually in insanity cases. What constitutes false imprisonment is, in brief, the restraint of the freedom of a patient against his will. This should never be resorted to except in cases where it is apparent that the freedom of the patient would result in dangers either to himself or society, and the law is that this danger must not be merely a possibility of danger but an actual and existing danger to either the patient or society.

It is apparent then, that restricting a patient to a sanitarium, hospital, or institution against his will is a criminal act unless it involves the element above referred to and steps to restrict the patient should never be taken except in the most extreme and violent cases. Contrary to general opinion, the number of cases arising from this condition bulk large in the field of medical jurisprudence and it is wise to be extremely careful of this condition.

The remaining subject to be discussed under the head of criminal responsibility, is that of criminal acts which are criminal per se such as abortions and other illegal operations and practicing medicine without a license. This branch hardly needs much discussion as it is obvious what constitutes the crime. A therapeutic abortion should never be performed without a consultation when possible. This, of course, is just common sense and a defensive and preventive step. Assistance rendered to persons on whom an abortion has been performed are naturally looked on with suspicion, but the rule of law adopted in most states is broad enough to protect the doctor in this instance and require the state prosecuting attorney to prove that the abortion was committed with the connivance of the doctor and the burden of proof in the State of Florida, and most liberal states, does not require the doctor to prove his innocence first, as there is no presumption that assistance to a patient after an abortion is evidence of the actual operation.

In conclusion, we wish to state that the field is broad and the subject important, and all the statements made are based on broad and general

principles and rules of law. We do not say that they cover each and every situation, but if we have called to your attention any of the dangers and traps occurring in the practice of medicine which might lead to legal liability, we shall feel that our efforts have been worth while.

REPORT OF A CASE OF LOBECTOMY WITH RECOVERY

L. W. Martin, M.D.,
Sebring.

Being aware that lobectomy by thoracic surgeons is no rare operation, though here in Florida we have comparatively few lung diseases that require such operations (or we do not recognize them as such) I felt it would be of interest to report this case. As months have passed since the above operation was done I can say with assurance the patient has completely recovered.

The patient, age 19, female and unmarried, was admitted to the hospital January 4, 1935, with the following history: In February, 1933, she had had lobar pneumonia followed by empyema and in March, 1933, a tube was put in the lower right chest which had been draining pus every since. On examination, the patient was very weak, weight 84 pounds, blood pressure 90-60, temperature 99.4, pulse 110, very anemic, with tube between sixth and seventh rib mid axillary line and draining pus freely. There was a large mass of granulation tissue about the tube, and the patient gave a history of spitting up large quantities of blood at times.

On January 5th, under gas anesthesia, granulation tissue was removed from about the opening in the chest and a larger tube was inserted into the lung cavity through which the lung was irrigated with normal saline. The patient seemed to improve and get stronger after this; her appetite was better and she gained weight.

On January 29th she had a severe pulmonary hemorrhage without warning and she spat up large quantities of blood which also ran out of the drainage tube. A blood transfusion was performed after which she improved for two weeks, when she again had another hemorrhage. This occurred several times. On the morning of March 2, she had a severe hemorrhage, and it was decided, against the advice of two colleagues, to operate. I had intended to resect only the rib and pack cavity. A long incision was made almost from sternum to spine and the seventh rib resected. The lung cavity was filled with blood and pus and atelectatic lower right lobe was recognized as the place from which the hemorrhage was coming. Adhesions and ligaments were separated and the lung mass clamped with curved forcep as near the hilus as possible. Part of the mass was tied with number 3 catgut and the lung mass removed. It was thought advisable to leave the clamp on the portion of the lung base which continued to bleed. The whole lung cavity was now irrigated and packed with gauze, with catheter in place near lung base for drain. Incision was now closed tightly about the catheter and hemostat, and the patient left the operating room very much better than when she entered. She has had an uneventful recovery with no hemorrhages and very little drainage. The incision was opened enough on the third day, under gas anesthesia, to permit change of gauze pack. This was done three times before it was left out on the twelfth postoperative day. She was discharged from the hospital April 21 with no drainage and weighing 95 pounds. She was again admitted to the hospital on October 24, 1935, with acute retrocecal appendicitis. The appendix was removed and the patient recovered without complications. She has been constantly under observation since and has gradually gained in weight and strength with no apparent lung pathology. Today she weighs 122 pounds, looks well and feels fine. There is very little collapse inward of the chest wall.

Your presence requested at

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Dubsdread Country Club
Orlando

August 29, 1936
beginning at 2 p.m.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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INDUSTRIAL COUNCIL—WORKMEN'S COMPENSATION

President Feaster has appointed a new committee to represent the Florida Medical Association on the Industrial Council. Before appointing this committee, Doctor Feaster conferred with Doctor Gilbert Osincup, chairman of the Executive Committee, and Dr. J. C. Vinson, chairman of the Committee on Medical Economics.

Mr. Wendell C. Heaton, chairman of the Florida Industrial Commission, has requested the formation of an Industrial Council with five members from the Florida Medical Association and five members each from the employers, employees and the insurors. This council will be advisory to the Florida Industrial Commission in the administration of the Workmen's Compensation Act. One representative each from the doctors, employers, employees and insurors will be in each of the five districts of the state so as to form sub-committees in Tampa, Jacksonville, Miami, Pensacola and central Florida. These men serve gratis as the present law provides no means for paying them for their services.

It is believed that this is a definite step forward in correcting some of the misunderstandings that are constantly cropping up with regard to disability and, particularly so far as we are concerned, with medical fees. It will essentially create a court of appeal when differences of opinion arise.

MATERNAL AND CHILD HEALTH

It has been suggested that two words be added to the name of the Committee on Maternal Welfare and that this committee be known as the Committee on Maternal Welfare and Child Health. President Feaster advises that this slight change in the name of the committee will be quite advantageous as it will enable us to make better use of the facilities offered by the Maternal and Child Health Service in cooperation with the State Board of Health and its Bureau on Maternal and Child Health. Four additional names have been added to the Committee on Maternal Welfare and Child Health, as follows: Luther W. Holloway, Jacksonville; William W. McKibben, Miami; C. C. Rudolph, St. Petersburg, and W. E. Sinclair, Orlando.

The doctors in Florida should benefit materially from the facilities offered to their county societies by the state and federal agencies through the medical postgraduate courses which are being planned.

Dr. E. Bryant Woods, Director of the Bureau of Maternal and Child Health of the State Board of Health, has definitely promised to give full cooperation even to the extent of proceeding only with the advice and counsel of the State Committee and the several county societies.

Dr. Homer Pearson, chairman, has called a meeting of the enlarged committee to be held at the Dubsdread Country Club, Orlando, at 4 p. m., Saturday, August 29. Doctor Woods will attend the meeting and lend his assistance in planning the year's work. It is hoped that the committee will succeed in arranging post-graduate medical institutes on maternal and child care, similar to those held in West Palm Beach, Miami, Ft. Myers, Tampa, Lakeland, Orlando and Daytona Beach in June. The enthusiasm with which these institutes were received indicates widespread interest among our members in the subjects treated.

MEDICAL POST-GRADUATE COURSE

At the Graduate Short Course for Doctors of Medicine held in Gainesville during the last week of June, the following physicians made up the faculty: Dr. Oscar W. Bethea, Professor of Clinical Medicine, Tulane University; Dr. Wilburt C. Davison, Professor of Pediatrics and Dean of Duke University School of Medicine; Dr. Charles Reid Edwards, Professor of Clinical Surgery, University of Maryland School of Medicine; Captain Walter S. Jensen, M. C., Director of Department of Neuropsychiatry, School of Aviation Medicine, Randolph Field, Texas; Dr. Emil Novak, Associate Professor of Obstetrics, University of Maryland; and Dr. Otto Henry Schwarz, Professor of Obstetrics and Gynecology, Washington University School of Medicine.

The week's course was divided roughly in halves, the first three days being largely devoted to medicine and the second to surgery. Under Medicine, Dr. Bethea took up the following topics: *Amebiasis; Avitaminosis; Thyroid Diseases; Vitamins in the Diet; Use and Abuse of Purgatives; Arthritis; Heart Pain (organic cardiac; angina pectoris; coronary).* Dr. Davison spoke on *Diarrhea and Dysentery—Infantile; Immunization in Infants; Infant Contagious and Infectious Diseases:* (Brucellosis; diphtheria; empyema; erysipelas; lung actinomycosis; meningitis; rabies; tetanus); *Infant Feeding; Rheumatic Virus:* (Rheumatic fever, acute; chorea); *Pneumonia,* lobar; *Congenital Syphilis.*

In presenting the course in Neuropsychiatry, Dr. Jensen took up *Child Psychiatry:* (Personality disorders: habits; tantrums; thumbsucking; juvenile paresis; eneuresis; masturbation); *Constitutional Psychopathic Inferiority; Fundamentals of Neuropsychiatry; Minor Psychoses:* (Hysteria; neurasthenia; psychasthenia; anxiety states; manic depressive psychoses); *Schizophrenia; Traumatic Neuroses and Psychoses.*

Dr. Schwarz took up the following aspects of Obstetrics: *Analgesia-Obstetric; Hemorrhage during Pregnancy:* (Placenta previa; antepartum and postpartum); *Labor:* (Breech delivery; pelvimetry; pelvis—normal and abnormal; dystocia mechanisms; treatment indications); *Pregnancy: Late toxemias:* (Low reserve kidney; eclampsia: nephritic and hepatic); *Puerperal Sepsis.*

Dr. Novak, taking up gynecology, spoke on the following topics: *Cervical and Uterine Carcinoma; Endocrine Therapy in Gynecology:* (Physiological basis; diagnosis; functional uterine bleeding; habitual abortion; menopause; estrogenic and estrogenic-like hormones); *Menstruation:* (Endocrine physiology; functional disturbances; amenorrhea.)

The course in Surgery as presented by Dr. Edwards consisted of the following subjects: *Breast:* (Infection and abscess; tumors); *Carcinoma,* rectal; *Gall-bladder Disease; Intracranial Injury; Oral Infections and Tumors; Rectal Diseases; Traumatic Surgery*—emergency; *Ulcers:* (Gastric; duodenal).

In addition to the daytime courses there were two symposia in the evening. Dr. H. Earle Conwell of Birmingham, Dr. Frank L. Fort of Jacksonville, and Dr. Arthur Weiland of Coral Gables spoke on *Fractures:* (Non-union, wrist, and elbow). Dr. W. Atmar Smith of Savannah, Dr. M. Jay Flipse of Miami, and Dr. George L. Cook of Tampa discussed *Respiratory Diseases:* Tuberculosis, pulmonary; (x-ray diagnosis and differential diagnosis); respiratory tract infections; x-ray pathology of the chest: (Abscess, amebic; asbestiosis; aspergillosis; atelectasis; bronchiectasis; brucellosis; carcinoma—bronchiogenic; empyema; foreign body; pneumonias—atypical; pneumothorax; spirochetosis; tuberculosis; tumors).

NOTE: We are indebted to Dr. J. H. Branan of Pensacola for the outline of the course from which the above resume was written.

Ninety-nine of Florida's 1,812 physicians registered for the Fourth Annual Short Course in June. In addition, those in attendance included the members of the committee and two visitors, making the number who derived benefit from the course approximately 105. The following paid registrants were present:

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Edwin H. Andrews.....Gainesville
Wilbur O. Arnold.....West Palm Beach
W. J. Baker.....Foley
T. H. Bates.....Lake City
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Annette M. Bieker.....St. Petersburg
J. F. Binkley.....West Palm Beach
Robert E. Blount.....Ft. Lauderdale
Louis R. Bowen.....Eustis
C. C. Box.....Graceville
J. H. Branan.....Pensacola
Z. Brantley.....Grandin
Reddin Britt.....St. Augustine
H. O. Brown.....Tampa
K. R. Cammock.....Gulf Hammock
J. L. Chalker.....Ocala
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Center Hill	1	Lakewood	1
Century	1	McIntosh	1
Chattahoochee	1	Melbourne	2
Chiefland	1	Melrose	1
Clearwater	1	Miami	3
Clermont	1	Miami Beach	2
Cocoa	1	Micanopy	1
Coral Gables	1	New Smyrna	1
Delray Beach	2	Nichols	1
Dunedin	1	Ocala	4
Dunnellon	1	Orlando	7
Eustis	3	Oviedo	1
Ft. Lauderdale	1	Panama City	2
Ft. Pierce	1	Pensacola	2
Foley	1	Quincy	2
Gainesville	11	St. Augustine	2
Graceville	1	St. Petersburg	8
Grandin	1	Tampa	2
Gulf Hammock	1	West Palm Beach	4
Hawthorne	1	Williston	1
Jacksonville	13		
Total number of towns			47

AMERICAN MEDICAL DIRECTORY

The directory, with nearly twenty-five hundred pages, is a vast storehouse of information. It contains not only the most complete list available of the physicians of the United States and its dependencies and of Canada, but much additional data which hospitals, libraries and various other institutions, as well as individuals, will find useful and readily available. The directory is the only nation-wide register of physicians in which the extensive data on medical education, licensure and society affiliations have been verified.

The 1936 edition contains 183,312 names, or 4,796 more than were in the previous edition issued in 1934. The names of 13,157 physicians have been added and 7,684 names have been removed because of death. More than 70,000 changes of address have been made, in addition to thousands of changes in society affiliations, teaching positions, specialties and office hours.

In this edition, thirty-two states show an increase in the number of physicians; New York leads the list with 1,201, followed by California, (369). Florida's increase is 99. A slight decrease in the number of physicians is shown in Missouri, Georgia, Kentucky, Tennessee, Oklahoma, Alabama, Indiana, South Dakota, Maine, Vermont, Mississippi and New Hampshire. When the thousands of changes of location are analyzed they seem to show a noticeable migration of physicians to the larger towns in the South Central states, a trend that was previously

present also in some other sections of the country.

The first section of 221 pages in the new directory includes the constitution and by-laws of the American Medical Association, the Principles of Medical Ethics, and a list of meeting places of the annual sessions of the Association since the first one in 1847, with the names of the President installed during each meeting. In this section also are lists of the hospitals that are approved for intern training, the medical libraries, the medical journals published in the United States, Canada, the Philippine Islands and Puerto Rico, the names of medical officers of the various government services, the national organizations for the various specialties with the names of their members, the membership of the new examining boards for the specialties, the medical schools in the United States and Canada with a brief history of each, and the members of the National Board of Medical Examiners.

The second section is arranged by states. There is published under each state the medical practice act, the members of the board of medical examiners, members of the state board of health, county and city health officers, and officers of the state, district and county medical societies. Following this is a list of 7,220 hospitals, sanatoriums and related institutions arranged by towns, with the name, location, bed capacity, superintendent, and type of patients treated in each institution. Then, arranged by towns, comes the great list of physicians, giving the year of birth, school, year of graduation and license to practice, membership in the state society and special societies, professorships, and Fellowship in the American Medical Association. The home and office addresses and office hours also are given for physicians in towns of more than 10,000 population.

A new feature in this edition is a key letter showing that a physician has been certified as a specialist by an approved examining board. Several of these boards have been approved by the Council on Medical Education and Hospitals since the directory went to press. The next edition therefore will contain a more complete list of certified specialists. An especially interesting feature of the 1936 edition is the list of American physicians temporarily located in foreign countries.

The third section, of 525 pages, is an alphabetical index of the names of 183,312 physicians; and practically every name is followed by the name of the city and state, thus indicating where in the directory detailed information about the individual physician may be found.

The Fourteenth Edition of the American Medical Directory has been completed and copies are now available for general distribution.

THE SECOND ANNUAL CLINICAL CONFERENCE OF THE FLORIDA SECTION OF THE SOUTHEASTERN SURGICAL CONGRESS AT THE ORANGE GENERAL HOSPITAL, ORLANDO, FLORIDA,

SATURDAY, AUGUST 29, 1936,
10 A. M., EASTERN STANDARD TIME.

COMMITTEES:

Committee on Clinics—
DR. J. S. TURBERVILLE, *Chairman*
DR. HENRY C. DOZIER — DR. EDWARD JELKS

Committee on Arrangements—
DR. FRANK D. GRAY, *Chairman*
DR. J. R. CHAPPELL — DR. J. S. McEWAN
DR. L. C. INGRAM — DR. L. M. ORR

DR. J. S. TURBERVILLE, *Presiding*

10:00 A.M.—"Aid in Diagnosis of Gall-Bladder Disease by Roentgenology", Dr. O. O. Feaster, St. Petersburg.

10:30 A.M.—"Malignancy in Gastro-Intestinal Tract", Dr. Edward Jelks, Jacksonville.

11:00 A.M.—"Perineal Repair" (Lantern Slide Illustrations), Dr. Walter C. Jones, Miami.

11:30 A.M.—"Perforating Duodenal Ulcer", Dr. J. C. Patterson, Cuthbert, Georgia.

12:00 M.—"The Aims of the Southeastern Surgical Congress", Dr. B. T. Beasley, Secretary, Atlanta, Georgia.

12:30 P.M.—Lunch; courtesy of the Orange General Hospital.

2:00 P.M.—"Hyperthyroidism", Dr. T. C. Davidson, Atlanta, Georgia.

2:30 P.M.—"Some Common Urological Problems and Their Treatment", Dr. J. O. Lisenby, Atmore, Alabama.

3:00 P.M.—"Uterine Displacements with Especial Reference to Indications for Treatment", Dr. B. T. Beasley, Atlanta, Georgia.

3:30 P.M.—"Cataract from the Standpoint of the General Practitioner", Dr. Shaler Richardson, Jacksonville.

4:00 P.M.—Adjournment to the barbeque at Dudsdread Country Club; courtesy of the Orange County Medical Society.

This program will consist of presentation of cases and case reports followed by discussions from the floor. There will be no set papers. All members of the Florida Medical Association are cordially invited to be present.

STATE NEWS ITEMS

Dr. Ralph Greene, formerly of Jacksonville, who is a Colonel in the medical reserve corps of the Army, is now stationed at Coral Gables where he is serving as chief of the section of aviation medicine in the office of the Surgeon General. He has also been appointed as medical examiner, Bureau of Aeronautics, U. S. Department of Commerce, and a member of this organization's National Board of Medical Consultants as a consultant in neurology and psychiatry. Doctor Greene is generally credited with being the pioneer flight surgeon of this country. He is a past president of the Aeromedical Association of the United States. Doctor Greene was among the first one hundred airplane pilots licensed by the Government, his license number being 40.

* * *

During the month of July, Doctor J. S. McEwan of Orlando was called to Chicago on consultation and while in the north, he took the opportunity to go to the Cleveland Clinic and Harvard University to take some special work.

* * *

The Committee on Medical Post-Graduate Course for 1937 held its first meeting during the 1936 Short Course. Dr. T. Z. Cason, Jacksonville, was reelected chairman of the committee, of which the following are members: Dr. George L. Cook, Tampa, Dr. Frank D. Gray, Orlando, Dr. E. Sterling Nichol, Miami, Dr. Bricey M. Rhodes, Tallahassee, and Dr. G. C. Tillman, Gainesville. The next meeting of the committee will be held in connection with the Orange County Medical Society annual picnic at Orlando in August.

* * *

YOUR INVITATION. All members of the Florida Medical Association are invited to attend a "stag" picnic.

The Orange County Medical Society will hold its annual picnic and barbecue at the Dubsdread Country Club Saturday afternoon, August 29, beginning at two o'clock and continuing as long as you wish to stay. The Dubsdread Country Club has just completed one of the finest open-air swimming pools in the State and those wishing to take advantage of this feature should bring their bathing suits. The Orange County Medical Society now has two steers being fattened for this event and will also have plenty of Brunswick stew and other things necessary to make such an affair a successful one.

Dr. and Mrs. H. T. Fenn of Mt. Dora spent the month of July in the mountains of North Carolina. Doctor Fenn attended the pediatric clinic at Saluda the latter part of the month.

* * *

The many friends of Dr. and Mrs. Louie Limbaugh of Jacksonville will regret to learn of the death of their six-year-old son, Miles, on July 25.

* * *

Dr. S. Allen Clark of Lakeland returned July 15 from Chicago where he had been observing obstetrical work at the Chicago Lying-in Hospital. He was accompanied by Mrs. Clark and they made a short stop in Asheville, N. C., on their return auto trip.

* * *

Dr. John F. Lovejoy, formerly of Dr. Campbell's Clinic, Memphis, Tenn., is now associated with Dr. F. L. Fort of Jacksonville. The practice of these two doctors is limited to orthopedic surgery.

* * *

Doctors John C. Turner and C. Kirby Smith of Miami announce the removal of their offices to 300 Ingraham Building.

* * *

Dr. and Mrs. B. F. Woolsey and small son of Jacksonville have returned from a two weeks' trip to Oklahoma City where they visited relatives. While there, Doctor Woolsey attended clinics at several of the hospitals, the University of Oklahoma Medical School being located there. They report that it was very hot and dry, the thermometer registering 110° on the day they left.

* * *

The Second Annual Clinical Conference of the Florida Section of the Southeastern Surgical Congress will meet at the Orange General Hospital, Orlando, Saturday, August 29, 1936, at 10:00 a. m. Please note preceding page for complete program.

* * *

The Ninth Annual Graduate Fortnight of the New York Academy of Medicine will be held October 19 to 31 and will be devoted to a consideration of Trauma; Occupational Diseases and Hazards. A complete program and registration blank may be secured by addressing Dr. Frederick P. Reynolds, 2 East 103rd Street, New York, N. Y.

Doctor Spencer Folsom of Orlando is taking special work on diseases of the heart at Pittsburgh.

JOSEPH NORMAN FOGARTY

Dr. J. N. Fogarty, former mayor of St. Augustine and for some years chief surgeon of the East Coast Hospital in that city, died in New York City May 5, 1936, at the age of sixty.

Doctor Fogarty was born in Key West, Florida, and received his medical education at Columbia University, New York. His death followed a leg infection which necessitated amputation at Jacksonville, after which he went to New York for special treatment.

He had served as president of the Monroe County Medical Society, councilor of the Florida Medical Association, acting assistant surgeon of the U. S. Marine Hospital, health officer and agent of the State Board of Health, and was elected physician and surgeon of two of the leading Spanish Societies of Key West. In 1907 he was elected mayor of Key West and was twice re-elected to the office, serving the city with distinction. With the coming of the Florida East Coast Railway in 1912, Dr. Fogarty was appointed one of the surgeons of the railroad in Key West and remained in that position until June, 1921, when he was appointed chief surgeon of the company with headquarters in St. Augustine. Dr. Fogarty was, for several years, mayor of St. Augustine and was elected, during that period, president of the Railway Surgeons Association of Florida.

In 1900 Dr. Fogarty married Miss Corinne Curry, a daughter of Charles and Sarah Curry. In religious faith he was an Episcopalian and for a number of years he was senior warden of Trinity Episcopal Church in St. Augustine.

Dr. Fogarty was personal physician to John D. Rockefeller, when the retired millionaire was in Florida.

It was said of him by his friends, who were legion, that at all times he was known as a public-spirited citizen whose interests and activity in the community in which he lived arose from a patriotic devotion and loyalty to the general good.

Doctor Fogarty is survived by his widow, Mrs. Corinne Fogarty; his mother, Mrs. Rosella Fogarty; and four sisters, Mrs. B. D. Trevor, Mrs. Stephen Lowe, Mrs. Julia Brooks and Mrs. Harry Price.



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JAMES HENRY COLSON

Dr. James Henry Colson died in Gainesville, Florida, March 6th, 1936, at the age of 69 years.

Doctor Colson was prominent in civic and professional affairs, having served as Senator from Alachua County and for a number of years preceding his death he was superintendent of the Florida Farm Colony.

Doctor Colson is survived by his widow, Mrs. Eloise Weeks Colson; a daughter, Mrs. Olin E. Watts of Jacksonville; three brothers, Lewis Colson of Columbia County, J. J. Colson of Lake Butler and Dr. Lemuell Colson of Mount Dora; and one sister, Mrs. D. W. Kelly, of Lake Butler.

Dr. T. E. Moore, formerly of Miami, is taking a year's post-graduate course in neurology and psychiatry at the Menninger Clinic, Topeka, Kansas.

* * *

Dr. Hewitt Johnston of Orlando is taking a post-graduate course in otolaryngology at the Washington University in St. Louis.

* * *

At the recent meeting of the Chattahoochee Valley Medical Society, held at Albany, Georgia, the following officers were elected:

President—Marion T. Davidson of Birmingham.
Vice-Presidents—Edgar H. Green of Atlanta and Clayton Royce of Jacksonville.
Secretary-Treasurer—F. K. Boland of Atlanta.

* * *

Dr. Ralph E. Stevens of St. Petersburg was recently appointed chief physician at the State Hospital, Chattahoochee, to fill the vacancy created by the resignation of Dr. J. H. Pound.

* * *

Dr. and Mrs. Gilbert Osincup of Orlando left recently for a European trip. They plan to spend some time in Edinburgh and London.

FOR SALE AT SACRIFICE.—Because of death of doctor, large general practice, established for over 25 years at Live Oak is for sale; also office equipment, Victor x-ray, diathermy and ultra violet-ray machines. This is the most complete and up-to-date equipment in this territory. A splendid opportunity for a physician. Write Mrs. H. M. Strickland, Live Oak, Florida.

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Only university recommended feeding formulae are used by Association dairymen.

The Association affords the most complete dairy control laboratory south of the Mason-Dixon Line.

"Home Milk" is a local product—not one gallon is imported.

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All herds are tested for tuberculosis.

Only Florida products are used when obtainable—Our milk bottles are made in Florida.

The Association operates the only Evaporated Milk Plant south of Baltimore, Maryland.

"Cellophane" Protective Hoods are an exclusive feature of "Home Milk."

We deliver from Pompano on the north to Key West on the south.

A. W. Ziebold, former Chief Dairy Inspector and later Director of Public Welfare for the City of Miami, is employed as general manager of the Association.

We offer deliveries to the home or through stores of Milk—Certified, Pasteurized, Raw—Buttermilk, Chocolate Milk, Cream, Cottage Cheese, and Butter.

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With our enlarged accommodation we are in a better position than ever to care for your invalid and neurological cases.

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ATLANTA, GA.

A registered medical institution for the diagnosis and treatment of internal diseases.

Physical methods: Full hydrotherapy; electrotherapy, sun bathing, swimming; newest colon apparatus.

We solicit your reference of cardio-renal, digestive tract, metabolic and arthritic cases; neuroses, sciatica, etc. Five pounds a week for underweights. A department for the Towns-Lambert regimes for addictions. Inviting rooms of hotel type; resort atmosphere. 418 Capitol Avenue, S.E.

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Prescribed in lotions and salves for dandruff, itching scalp and falling hair



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Alcohol 65%
Rub into scalp
every other
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COMPONENT COUNTY SOCIETIES

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

A regular meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Simmons Hotel, Wauchula, July 14 at 8 p. m. Members present were: H. P. Bevis, M. C. Kayton, G. S. McKnight, L. W. Martin, A. A. Poucher, W. S. Pyatt, J. A. Simmons, and B. D. Spears; visitors, Joseph Halton of Sarasota and F. E. McDaniel, Sebring. The application of Dr. F. E. McDaniel for membership in the society was read and referred to the Board of Censors.

The scientific program consisted of a paper on "X-ray Therapy" (supplemented by x-ray films and diagrams) by Dr. Halton.

It was decided to hold the August meeting of the society in Arcadia.

ORANGE COUNTY MEDICAL SOCIETY

All members of the Florida Medical Association are invited to a "stag" picnic which will be held Saturday, August 29, at the Dubsdread Country Club, Orlando. A write-up of this picnic will be found among the news items of this Journal.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. John J. Bourke of Dade City was host to the Pasco-Hernando-Citrus County Medical Society and the Sumter County Medical Society at the Edwinola Hotel in Dade City on July 9th.

After dinner served in the hotel dining room, the doctors held their regular business and scientific meetings. It was decided not to hold an August meeting but to meet in September in Brooksville at the opening of the new Brooksville Hospital.

The doctors present were as follows: Drs. Cox, Harvard and Creekmore of Brooksville, Dr. Wood of Oxford, Dr. Mitchell of Coleman and Drs. Bradshaw, Sistrunk and Bourke of Dade City.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held a dinner meeting at 6:30 p. m., Friday, July 17, at the Shrine Club. Doctor E. C. MacCordy of St. Petersburg was the principal speaker, choosing as his subject, "U. S. Public Health Service."

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VITAMINS IN CANNED FOODS

II. VITAMIN D

• One of the most interesting chapters in the history of the science of nutrition is that relating to vitamin D. It is a record of steady advances in our knowledge concerning the vitamin. Starting with the work of Huldschinsky in 1919 on the ultraviolet irradiation of rachitic children; passing to the classical discovery in 1924 by Steenbock (1) and by Hess (2) that irradiated foods may acquire antirachitic potency; and extending through the profound studies of Windaus (3) and other investigators, on the constitution of the pure vitamin D obtained by ultraviolet irradiation of ergosterol, the story of vitamin D is a story of steady, scientific progress.

As a result of these basic contributions, there are available today a number of excellent standardized carriers of vitamin D. Viosterol, and the fish liver oils, and their concentrates, are readily available for use in the campaign against rickets whose prevalence, especially among infants in large urban centers, still remains high. In addition to these vitamin D carriers, the vitamin D fortified or irradiated foods have appeared within recent years.

It has become increasingly evident that there are a number of compounds which may promote calcification in the various animal species. It is further evident that these compounds vary in their physiologic efficiency with various animal species, or that they are "species specific". A number of forms of vitamin D have been postulated (4) and much research in the vitamin D field has been directed toward their isolation and identification.

In general, natural foods have never been regarded as important sources of vitamin D. The commonest food articles show extremely low antirachitic potencies when measured by conventional methods. However, recent evidence has been offered that the contribution of vitamin D made by a varied diet of canned foods may be more significant than has heretofore been supposed (5). While common foods admittedly cannot supply the high demands of infancy and childhood or other phases of the life cycle, for vitamin D, it would appear that they may supply significant amounts of the vitamin to the diet, especially in the case of the adult human, concerning whose quantitative vitamin D requirement comparatively little is known.

Biological research has shown that canned marine products such as salmon, shrimp, and oysters (6) make a small but definite contribution of the antirachitic factor to the diet. We desire to direct the attention of our readers to these interesting facts about canned foods in general, and these canned marine products in particular.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1924. J. Biol. Chem. *61*, 405
(2) 1924. J. Biol. Chem. *62*, 301.
(3) 1932. Ann. *492*, 226
(4) 1935. Physiological Reviews *15*, 1-97
(5) 1934. Ind. Eng. Chem. *26*, 758
(6) a. 1935. J. Home Econ. *27*, 668
b. 1933. Science, *78*, 368
c. 1926. Wis. Agr. Expt. Sts. Bul. *388*, 124

This is the fifteenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

SARASOTA COUNTY MEDICAL SOCIETY

THE SARASOTA COUNTY MEDICAL SOCIETY IS NOW 100% PAID FOR 1936. THIS SOCIETY, WHICH DRAWS ITS MEMBERS FROM SARASOTA, HOLOPAW AND VENICE HAS A MEMBERSHIP OF SIXTEEN. CONGRATULATIONS, SARASOTA COUNTY SOCIETY!

ADVERTISERS' NOTES

Air Conditioning Comes to the Animal Laboratory

We are reminded almost daily that we are witnessing the beginning of a new era of increased comfort of living, better safeguarding of health and greater efficiency due to the adoption of air conditioning in homes, stores, offices, theatres and hospitals. But while it is easy to appreciate the benefits to human beings from the proper regulation of the temperature and humidity, and the removal of irritant gases from the air we breathe, only a trained laboratory worker immediately visualizes the advantages of maintaining laboratory animals in surroundings where the atmospheric conditions are regulated with as great care as in homes or hospitals.

The Lilly Research Laboratories have evidence gained from such care of experimental animals over a period of almost two years, that not only is the number of guinea pigs, rats, rabbits, cockerels, and other animals which ordinarily die because of the heat and other devitalizing effects of summer, reduced to a minimum but pharmacologic assays and research experiments yield much more dependable results. These observations are proof of an indirect benefit which we enjoy from air conditioning because, surely, biologic assay is a cornerstone of modern medicine.

Antivenin

Concurrent with the reports of more than 600 persons being bitten by the "Black Widow Spider" with a mortality record of 40, comes the announcement that E. R. Squibb & Sons are now supplying Antivenin (Anti-Black Widow Spider Serum.) Widespread professional interest has been shown in methods of treating these bites, especially with the steady increase in the number of cases reported from southern, southwestern and western sections of the United States.

Antivenin is prepared by the hyperimmunization of sheep with repeated doses of venom from the black widow spider. The serum is standard-

FOOD-DRINK ADDS AVAILABLE IRON TO THE DIET!

ALSO RICHLY PROVIDES CALCIUM, PHOSPHORUS AND VITAMIN D

Cocomalt, the delicious chocolate flavor food-drink, is a rich source of available Iron. An ounce of Cocomalt (which is the amount used to make one cup or glass) supplies 5 milligrams of Iron in easily assimilated form.

Thus three cups or glasses of Cocomalt a day supply 15 milligrams — which is the amount of Iron recognized as the normal daily requirement.

Used as a delicious food-drink, Cocomalt provides a simple, palatable means of furnishing Iron to growing children, convalescents, expectant and nursing mothers.

...and for bones and teeth

In addition to Iron, Cocomalt is rich in Vitamin D — containing at least 81 U.S.P. units per ounce. Cocomalt is fortified with Vitamin D under license granted by the Wisconsin Alumni Research Foundation.

Cocomalt also has a rich Calcium and Phosphorus content. Each cup or glass of this tempting food-drink provides .32 gram of Calcium and .28 gram of Phosphorus. Thus Cocomalt supplies in good biological ratio three food essentials required for proper growth and development of bones and teeth: Calcium, Phosphorus and Vitamin D.

Easily digested — quickly assimilated

Not the least of Cocomalt's many virtues as a food-drink is its *palatability*. It is so refreshing, so delicious, it appeals even to the very sick. And though it provides exceptionally high nutritional fortification, it is easily digested, quickly assimilated, imposes no digestive strain.

Recommended by you and taken regularly, Cocomalt will no doubt prove of great value to many of your patients.

FREE TO DOCTORS

We will be glad to send a professional sample of Cocomalt to any doctor requesting it. Simply mail this coupon with your name and address.



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Please send me a trial-size can of Cocomalt without charge.

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THE ALLERGIC NOSE

A LARGE number of allergic patients require the constant use of a vasoconstrictor to maintain the patency of the nasal passages. With prolonged use, most vasoconstrictors—such as ephedrine and epinephrine—not infrequently produce tolerance or atony.

Benzedrine Inhaler continues to give efficient shrinkage even when used over a prolonged period of time, and secondary returgescence following its application is reduced to a minimum.

CASE HISTORY: A. P., age 32, male, white. A plumber hypersensitive to dust; nasal mucosa chronically engorged. Observed at weekly intervals at Nose and Throat Clinic of a Philadelphia hospital.

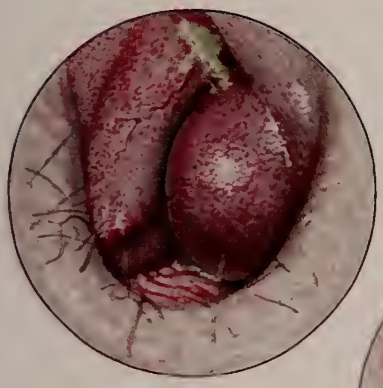


FIG. 1. Nov. 27. Nose in unshrunken state after 14 days of spraying twice daily with ephedrine, 1% in oil. Mucosa engorged, bluish, turgid and irritated; inferior turbinate blocking nostril. Marked tolerance to treatment had developed.

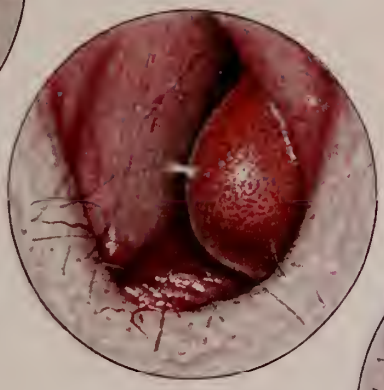


FIG. 2. Dec. 13. Nose in unshrunken state after 16 days treatment with Benzedrine Inhaler, three times daily. Engorgement reduced, tone good, irritation relieved. Note absence of atony.

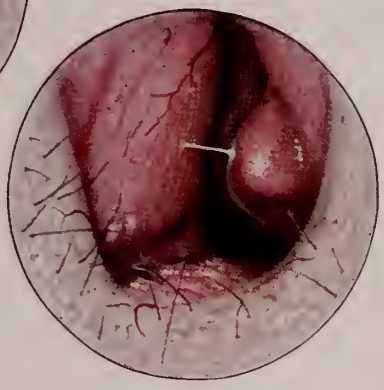


FIG. 3. Dec. 13. Nose in shrunken state seven minutes after application of Benzedrine Inhaler. High degree of shrinkage indicates no tolerance even after continued use.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

BENZEDRINE INHALER

A Volatile Vasoconstrictor

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

ESTABLISHED 1841



IN HAY FEVER
The Child Patient

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Furthermore, the safety of Benzedrine Inhaler makes it especially suitable for pediatric use; it has been shown to have no deleterious effect even on the delicate cilia of the nose. Since it is volatile, it cannot disseminate a local infection by physical means—as it has been suggested that irrigations may do (Rucker: U.S. Pub. Health Reports, No. 30, 1927). Nor is there any oil to be aspirated and become a potential source of later trouble by accumulating in the lungs (Graef: Am. J. of Path., Vol. XI, No. 5, Sept. 1935).

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The Physicians Casualty Association of Omaha has recently published its report for "34 years of uninterrupted usefulness" in which they show payments to physicians for sick and accident claims of $535,052.98—over half a million dollars. The report further shows they have a surplus fund of $1,350,000 as evidence of their financial ability to pay what they promise to sick or disabled members.

The Borden Digest
(Summary of May Issue)

Metabolism tests on infants fed on sweetened condensed milk have demonstrated that this product furnishes adequate protein, since nitrogen balances of the infants were favorable when 10 per cent of the calories was in the form of protein. As reported in Abstract No. 48, condensed milk formulas produced satisfactory gains in weight, and also gave adequate retentions of calcium and phosphorous.

When infants were given whole milk curded with lactic acid or citric acid, and uncurded evaporated milk, the nitrogen, calcium and phosphorus retentions increased with the intake, according to the investigation set forth in Abstract No. 49, in which it is stated that the results of this study prove the value of these forms of milk for infant feeding.

The unique advantages of certified milk are described in the article which is the basis of Abstract No. 50. When pasteurized, certified milk averages only 100 bacteria per cubic centimeter.

Rickets of some degree was found in 97.6 per cent of 1000 private patients, according to the paper reviewed in Abstract No. 51. Irradiated vitamin D milk is characterized in this article as the most reliable and natural preventive of rickets.

The failure of viosterol to prevent mild rickets in premature infants is reported in Abstract No. 52.

Vitamin A deficiency is widely prevalent among children, as revealed by the findings of the study summarized in Abstract No. 53.

The value of milk and protective foods in the diet, and the favorable influence of higher incomes on the consumption of these foods are described in the articles mentioned in Abstracts Nos. 54 and 55.

New books on pediatric nursing and on feeding children in nursery schools are reviewed in Abstracts Nos. 56 and 57, respectively.

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★ *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11

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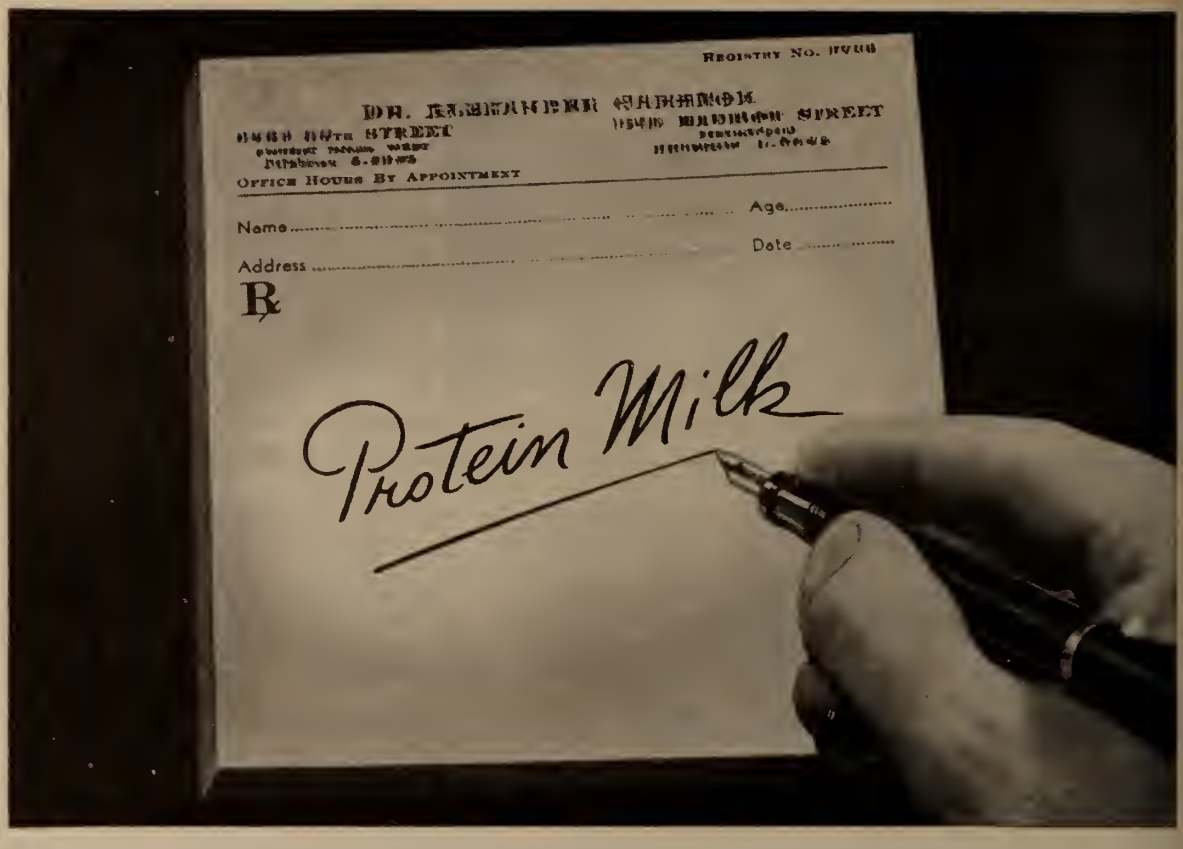
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"Simplified Infant Feeding," Dennett, Lippincott. 1926. Page 141.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	23	85%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			11	92%
Brevard	I. F. Bean, M.D., Melbourne	Boh Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	4	50%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	24	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	10	100%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Tbrelkeld, M.D., Congress Bldg., Miami	1st Friday 8:30 P.M.	Rod and Reel Cluh Hihiscus Island	205	92%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sehring	2nd Tuesday 8:00 P.M.	Varies	15	75%
Duval	W. M. Sbaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	141	93%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	38	93%
Hillshorough	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grahle, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	112	94%
Jackson	C. D. Whitaker, M.D., Dekle Bldg. Marianna	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	8	62%
Lake	R. H. Williams, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM..	Eustis	16	100%
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallabassee	Quarterly 3:00 P.M.	Varies	34	97%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
Manatee	S. G. Hollingswortb, M. D. 451 12th. St, Bradenton	M. M. Harrison, M. D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Cluh Bradenton	11	100%
Marion	J. N. Moore, M.D., 210-12 Professional Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	22	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	4	100%
Orange	William E. Sinclair, M. D. Clinic Bldg. Orlando	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies	56	100%
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	51	91%
Pasco-Hernando-Citrus	R. D. Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Tbursday 7:00 P.M.	Varies	11	85%
Pinellas	T. E. Kauffman, M.D Coacbman Bldg., Clearwater	W. C. McConnell,, M. D. 1005 Equitable Bldg. St. Petersburg	1st. and 3rd. Friday 6:30 P.M.	Shrine Cluh St. Petershurg	81	100%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feh.. April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	51	86%
Pntnam	Allen P. Gurganious, M. D. Palatka	A. E. Drexel, M.D., Palatka	2nd Tbursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Johns	Herbert E. Wbite, M.D., 401 First Natl. Bank Bldg St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	9	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies	9	82%
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	16	100%
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	12	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies	4	100%
Taylor	J. C. Ellis, M.D., Perry	J. L. Weeks, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	5	83%
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Cbowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies	36	95%
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies	6	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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THE JOURNAL
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Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XXIII
NO. 3

Jacksonville, Florida, September, 1936

Yearly Subscription, $3.00
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THE N.Y. ACADEMY OF MEDICINE
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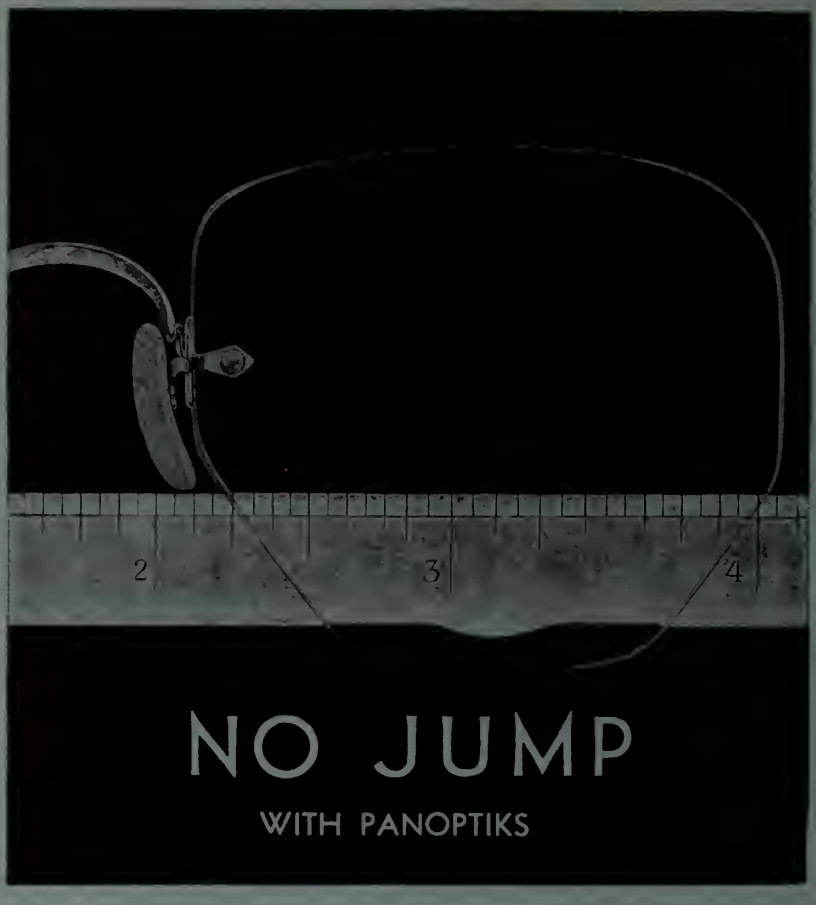
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Florida Medical Association, St. Petersburg, April 5-6-7, 1937.
American Medical Association, Atlantic City, 1937.
Southern Medical Association, Baltimore, Md., November 17-20, 1936.

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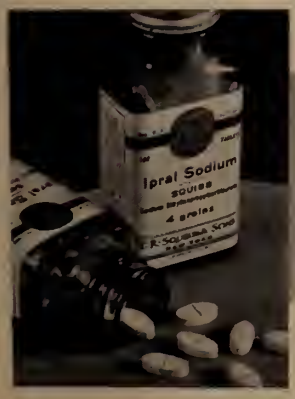
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III. VITAMIN A

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That vitamin A exerts an influence on the growth of human infants and children is also generally accepted.

As early as 1919, a relationship between vitamin A in plant foods and plant pigments was postulated. Research since that date has indicated that beta-carotene and some related compounds may be considered as provitamin A (3).

The vitamin A potency of fruits and vegetables is apparently due to their carotene content, since vitamin A as such has never been found in plant tissue. Ingested carotene is believed to be converted into vitamin A by enzyme action in the liver of the animal (4), in which organ the vitamin is stored.

Vitamin A in the form of carotene may be present in yellow, green or red pigmented fruits and vegetables—in the two latter cases, the yellow color of carotene being masked by other pigments present. Color alone, therefore, is not always a reliable index of potential vitamin A potency.

Both vitamin A and carotene are relatively stable to heat but are subject to destruction by oxidation. However, foods of both animal and plant origin, when canned by modern methods, have been found to retain their vitamin A potencies in high degree (5).

In fact, in some instances, practically no loss of vitamin A potency can be detected by formal bio-assays (6).

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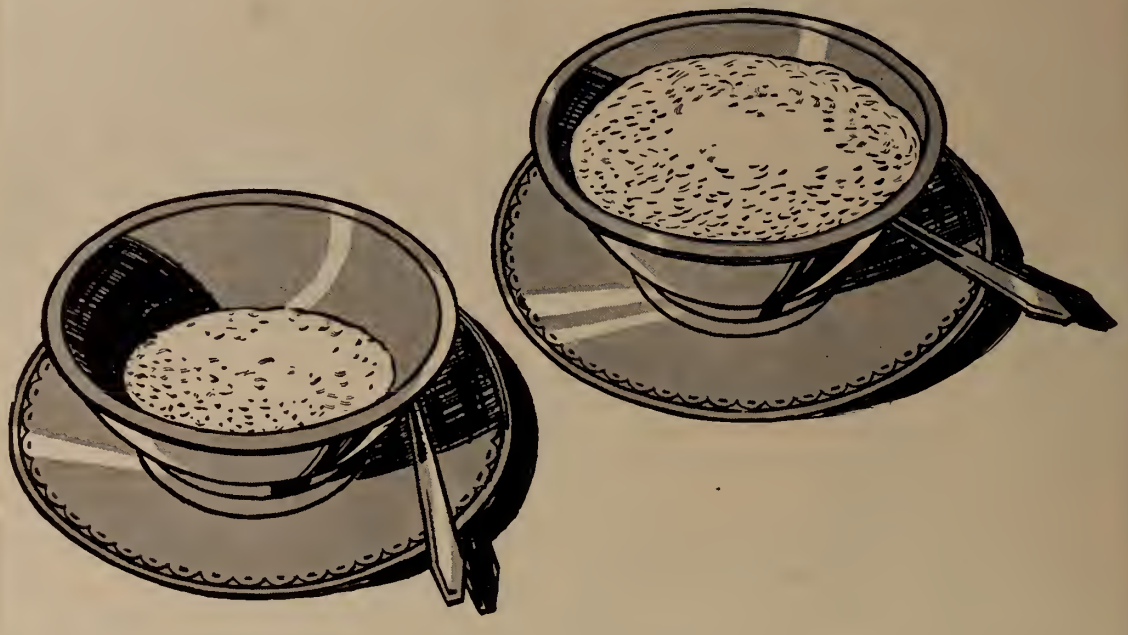
(1) 1927. J. Exp. Med., *46*, 699
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(6) a. 1925. Ind. Eng. Chem., *17*, 69
b. 1926. Ind. Eng. Chem., *18*, 85

This is the sixteenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXIII | Jacksonville, Florida, September, 1936 | Number 3

THE CAUTERY IN ACUTE EPIDIDYMITIS AND ORCHITIS*

J. C. Vinson, M.D.,
and
Julio J. Guerra, M.D.,
Tampa.

Before the Section on Urology of the Southern Medical Association's thirteenth annual meeting in 1919, cautery puncture in acute epididymitis was presented as an original contribution. This paper represents a recapitulation of this particular method in the treatment of acute epididymitis with the addition of its use in acute, inflammatory swelling of the testicle.

Since the introduction of this method, we have never found it necessary to resort to any other form of treatment and have been convinced conclusively of its remarkable success in the conditions for which it was first indicated.

There has never been developed any other method that offers such a sane and easy means of conserving a swollen testicle. It has been definitely proven that where the puncture of the testicle is made with the cautery, no herniation occurs, and that the loss of the seminiferous tubules does not occur.

Indications: *Acute Epididymitis:* All forms of acute epididymitis, no matter of what origin, either infectious or traumatic. *Orchitis:* All cases of acute orchitis, whether due to infection or trauma.

Technic: The instruments necessary for this procedure consist of a small transformer, cord, and cautery. The cautery point is about 3 mm. in length and .2 mm. in width.

The usual preparation of the surgical field is made. The local anesthetic of choice is 1 per cent novocaine. The cord is anesthetized high up in the scrotum. The testicle is firmly grasped with the left hand, and a skin infiltration is made. The cautery at white heat is plunged through the skin and into the swollen area.. The technic for a puncture of the testicle differs only in making from four to six separate punctures through the covering of the testicle. There is no particular reason why the cautery point should remain in the area any longer than is necessary to puncture the tunica. A sterile vaseline dressing is applied to the puncture, a suspensory bandage is fitted, and the patient is instructed to change the dressing as is necessary.

Results: *Epididymitis: A.* Immediate: We have yet to encounter a single case of acute epididymitis that has not been relieved of pain, infection, and swelling.

B. End: We are of the opinion that a cautery puncture of the epididymis offers the best chance for the restoration of normal function. We have had under observation a number of cases in which bilateral epididymitis occurred in a virgin field and where, subsequently, after a clean-up of the infection, we were able to demonstrate normal spermatozoa. A number of these patients have become the fathers of children.

Orchitis: A. Immediate: Relief of pain in the swollen testicle is immediate and certain.

B. End: The conservation of the testicle depends entirely upon the early application of this method. Atrophy of the testicle can be prevented by the early use of the cautery puncture. The amount of atrophy will depend upon the amount of damage done before this method has been instituted.

DISCUSSION

Dr. James L. Estes, Tampa:

The essayists have brought to us, in a clear concise manner, their method for relieving pain in gonorrheal epididymitis. Epididymitis is a frequent complication of a gonorrheal infection. It occurs oftentimes in spite of the most meticulous care given to the patients but, in spite of that, we should not let up on our efforts in preventing this troublesome and painful complication. In the majority of cases it is the result of inadequate treatment, assisted by trauma, either from medication or from excessive physical exertion. It is not always practical to put the patient with an acute anterior urethritis to bed until local resistance and outward drainage are established.

A patient with a congenital narrow meatus

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held aboard the SS. "Florida", April 27, 28 and 29, 1936.

that develops gonorrheal urethritis is more likely to develop posterior complications and subsequent epididymitis than the one with a wide meatus where good drainage takes place.

I wish to urge those men who are treating gonorrhea to be gentle, both in handling the tissues and in applying local medication. The first week or ten days is the most important time. Do not try to stop the discharge too soon. No medication can be instilled in the urethra that will destroy all the organisms. If the medication is too strong, the tissues are insulated, the secretion is prevented from draining outwardly and, as a natural consequence through direct extension and lymphatic drainage, the patient develops a complicated prostatitis and vesiculitis and sometimes epididymitis.

Have no fear in doing a wide meatotomy, even in the presence of an acute infection. When epididymitis is once established, the patient is almost always incapacitated and we should certainly attempt to institute means of relief of this troublesome infection. In my early training in urology, I employed the cautery puncture method of relieving the pain in these cases. It is an absolute fact that the swelling does not reach the degree following cautery puncture of the epididymis if instituted early as it does when left alone. The pain is relieved early following puncture and the patient is able to be up and about sooner than when not employed.

A few years ago, I had the pleasure of appearing on the program of the Southern Medical Association as a discussant of a paper presented by Doctor Taylor of Oklahoma, on the subject of "The Use of the Cautery Puncture in Relief of Gonorrheal Epididymitis." Doctor Taylor's cases were among the workers in the oil fields and it was imperative that they return to their work at the earliest possible moment. He clearly showed that the many patients so treated were able to return to their work in half the time required for those treated without the puncture.

I wish to sound a warning against the injudicious use of diathermy in the treatment of epididymitis. I have had the opportunity to observe a number of cases where necrosis and subsequent slough of the testicle developed following prolonged use of diathermy. Diathermy does relieve the pain but can also cause a slough and the loss of a testicle. The use of gonorrheal filtrates has enjoyed a wide range of popularity. In my experience it has proven of little or no value as an adjunct in the treatment of gonorrhea and its complications, and I predict that soon the true facts will be known, that the gonorrheal filtrates now in use will be relegated to the position of many other remedies that have been tried and found wanting.

The use of foreign proteins, manganeses and iodides are still valuable adjuncts in the treatment of gonorrheal epididymitis and personally, if I had gonorrheal epididymitis, I feel that I would want to be treated by less radical means than with the cautery. The use of the cautery in the treatment of orchitis following the mumps, in my opinion, is most valuable.

I have had occasion to observe patients with a bilateral orchitis following mumps, where the cautery puncture was used, who had subsequent active spermatozoa in the ejaculated fluid. I have not found any cases of active spermatozoa where there has been a bilateral gonorrheal epididymitis in which the cautery puncture was used. In cases where pain is the greatest factor I feel the use of the cautery is a distinct benefit, but as to its preventing sterility, I have my doubts. I thank you.

Dr. George H. Day, Miami:

I would like to take up one point, and to congratulate Doctors Vinson and Guerra on their splendid paper.

Using the Hagner operation, I have operated upon nearly one thousand patients but I do not remember one with a bilateral infection who is not sterile. If Doctors Vinson and Guerra do nothing else with this operation than to get spermatozoa after the operation, I will say that that is more than the Hagner operation has ever been able to do insofar as I know.

Dr. J. C. Vinson, Tampa (concluding):

Both the epididymis and the testicle are covered with that type of membrane which limits the amount of swelling, and due to this fact an intervention by the cautery puncture obviously decreases the amount of intramural damage.

I wish to emphasize two points: first, the relief of pain; second, the restoration of normal-functioning organs if the method is instituted sufficiently early.

I wish to thank the gentlemen for their free discussion of this paper.

THE TREATMENT OF ACUTE LOBAR PNEUMONIA*

Fred Mathers, M.D.,
Gainesville.

Before discussing the therapy of lobar pneumonia let us consider certain features of the problem presented by this disease. First, what are the special points in the pathological physiology which must be considered; and second, upon what does recovery depend? We know that the body tissues are required to combat an infection: that there is an associated anoxemia; and frequently a neurocirculatory weakness. According to Hektoen,[1] recovery depends upon a destruction of pneumococci in the lung tissues and blood by phagocytosis and extra-cellular digestive processes. Therefore, the greatest defence against this disease is the production of phagocytes and antibodies in the blood. If this defence mechanism occurs rapidly, we have recovery by crisis; if slow, by lysis; and if insufficiently, recovery is impossible. Bearing these facts in mind, let us consider the management of lobar pneumonia.

Prophylaxis: Since pneumococci of types I, II, and III account for three-fourths of the cases and since these organisms are never found in the mouths of individuals not in the environment of persons ill with pneumonia it is obvious that infection comes from without. Consequently, strict isolation should be enforced. Gowns and masks should be worn by all attendants. Dishes, utensils, and linen must be properly cleansed and sputum must be properly disposed of. The production of immunity to types I, II, and III, pneumococci is definitely possible. For this purpose, three doses of a polyvalent vaccine in saline suspension given subcutaneously at weekly intervals is recommended by Park. Cecil advises its use in individuals subject to recurrent attacks. It is contraindicated in acute disease, chronic cardiac and renal conditions, and possibly pregnancy.

Perhaps the main prophylactic measure is proper treatment of the common cold and influenzal infections. Certain features of the general treatment of lobar pneumonia are important. Despite recent advances in therapy, the resistance of the host is still the important factor and any measure, regardless of how slight, which will increase the physical and mental comfort of the patient deserves consideration. There is no other disease in which good nursing care is more essential.[2] A good nurse should be familiar with the disease and be able to recognize promptly any change in the patient's condition. She should keep accurate bedside notes, a record of the intake and output, character and amount of the sputum, and, if possible, be familiar with oxygen administration and understand the complications following serum administration. Above all, she must not be allowed to worry the patient by continuous fussing about him, but must never neglect the details which are essential in conserving the patient's strength. Absolute rest is essential. The patient must not be allowed to turn himself or lift himself upon the bedpan. He must be fed by the nurse. Visitors should be restricted to a minimum. A comfortable position is necessary. The Fowler's or semi-Fowler's position is desirable. Sedatives should be used as needed to ensure rest. Barbital or its derivates and chloral hydrate are useful. Morphine may be used early during the stage of acute pleuritic pain, but its tendency to increase abdominal distension and decrease aeration detract from its value. Strapping the chest prevents examination and is soon uncomfortable.

The room should be well ventilated and cool. The tepid bath once daily is more desirable than frequent sponges. The back requires special care and pure alcohol should be used for sponging. The patient should never be left with bed clothes and gown saturated when profuse sweats occur.

Cleanliness of the mouth is extremely important since mouth breathing is common.[2] A dry, dirty, oral cavity furnishes a potential danger since re-infection or super-infection may result. Moreover, it impairs the sense of taste and an adequate intake of fluid and food is prevented. Scrubbing of the oral cavity every two hours with an alkaline mouthwash and covering the tongue with alboleine and the lips with cold cream is satisfactory. A simple nasal spray should be used frequently.

As the disease is of a relatively short duration, the maintenance of an adequate caloric intake is not of major importance, but a high fluid intake is essential.[2] At least 3000 cc. every 24 hours and if possible 5000 cc. should be sought for. It seems best to furnish 50-60 gms. of protein daily and as high a carbohydrate intake as possible so as to prevent acidosis and to furnish energy for the extra metabolic activities of the

*Read before Alachua County Medical Society, March, 1936.

body. Glucose in the form of 50% solution can be injected intravenously to increase the available carbohydrates. The bulk of the diet should be in liquid form: fruit juices, well sweetened with lactose or glucose; cereal gruels; thin soups; eggs; custards; creams; broths; tomato juice; milk; buttermilk; and tea and coffee can be used, consideration being given to the individual's preference. Abundant salt administration is advised since there is a chloride deficit. If tympanites develops early, milk is best eliminated, as are tea and coffee if sleeplessness results. Dilute hydrochloric acid minims 10 can be given with meals as an aid to digestion. Alcohol in moderation in individuals accustomed to its use seems desirable.

The bowels require careful attention. A small enema is given daily to prevent abdominal distension. This condition to a variable degree is part of the disease picture and, as it is harmful in proportion to the degree to which it limits respiration, it must be carefully watched for and actively combated. A rectal tube, enemas, stupes or poultices to the abdomen frequently relieves the lesser degrees. If it becomes marked, pituitrin 1 cc. should be given subcutaneously every 20-30 minutes for two or three doses. Physostigmine seems to be too indefinite in its action to be dependable.

It may seem a waste of time to discuss the many small details of general treatment and nursing care, but too frequently they are neglected and the energy expended by the patient in their absence may mean the difference between recovery and death. I feel that the attending physician too often assumes that the nurse is familiar with these details and does not take trouble to give proper instructions or demand their being used.

In considering the general medicinal care and symptomatic treatment several drugs may be mentioned.

Expectorants are not routinely necessary though ammonium chloride in 5 grain doses mixed with lemonade will aid if the sputum is viscid and tenacious. For the frequent, dry, harassing cough codeine gr. ½ should be used.

Antipyretics are to be avoided since they all have a depressant action upon the heart. Reliance is placed more upon tepid sponges for the control of excessively high temperatures.

For the procuring of sleep the barbiturates and chloral are useful. Morphine may even be used since sleep is essential.

For the delirium, chloral hydrate in 15 gr. doses or paraldehyde 30 minims may be given; an ice cap should be placed upon the head; and constant watching instituted since the patient may do irreparable harm to himself. At times this condition is particularly difficult and if extreme measures are necessary avertin 60 mg. per kilogram of body weight may be given rectally.[3]

The heart must be watched continually and must be spared all possible exertion. It is advisable to examine the circulatory system just as carefully as the lungs. This should be done at the beginning of the illness in order to have an accurate conception of any changes or weakness that may ensue. The efficacy of digitalis as a routine measure in pneumonia has been long debated. Cohn showed that its use as a routine measure produced auricular fibrillation and even complete heart block in a definite proportion of cases.[4] This fact is borne out by experimental evidence that fibrillation of the auricles is more easily produced when a state of anoxemia exists.[4] It is used early as a routine by the staff of the hospital of the Rockefeller Institute[5] and[7] by some internists with the theory that the heart, being thus partially digitalized, will respond more rapidly to the drug if occasion demands. This practice has never been shown to be of clinical value and is both unnecessary and dangerous. In the occasional case of auricular fibrillation or flutter, or when decompensation is present digitalization is indicated just as it is in these conditions per se. It is probably safer to confine its routine use to those individuals over forty years of age whose circulation is feeble at the onset, and in those having a pre-existing cardiovascular disease or a history of rheumatic fever. For this purpose 1½ gr. of the powdered leaf or the equivalent amount of the tincture three times daily from the beginning may furnish improved myocardial tone. The great danger from its use is its toxic action upon the vomiting center so its effects must be carefully watched.

The use of caffeine in the form of tea and coffee was mentioned in discussing the diet. There is perhaps no other drug with the exception of epinephrin (whose action is fleeting) which will raise blood pressure in serious conditions. It may be given by mouth or by rectum as a coffee enema or hypodermically in the form of the sodiobenzoate. It is a vasodilator, increases

urinary output, and stimulates the cerebrum. It is also useful when mental depression exists, but it is to be avoided if producing sleeplessness. Its action on the heart is always good except in the rare cases of idiosyncrasy.

Strychnine at times may seem beneficial, but is frequently over used.[5] It should never be given in doses greater than 1/30 gr. every six hours and never long continued.

Pituitrin 1 cc. hypodermically every 3 hours helps to maintain the peripheral vascular tone and raise blood pressure as well as counteracts tympanites. It is a valuable drug.

Fifty cc. of glucose intravenously will furnish readily available nutrition to the myocardium if that seems to be a factor in its failure.

For right heart failure with venous engorgement and pulmonary edema atropine gr. 1/75-1/50 hypodermically should be given. Venesection if tried should be repeated two or three times withdrawing 600-800 cc. of blood each time.

Respiratory failure, cyanosis, and dyspnea require special treatment. If the cyanosis is excessive without dyspnea indicating a depression of the respiratory center lobeline can be given hypodermically in 1/20 gr. doses every ½ hour until improvement occurs.

German authorities use camphor for this condition. Since its absorption is slow it is given early in the form of 20% in oil. Several intramuscular deposits of 5-10 cc. amounts are used.

In the plethoric, full-blooded individuals with moderate hypertension erythol tetranitrate gr. ¼-½ every 4 hours seems beneficial.[1]

It is best not to depend upon drugs in the treatment of anoxemia since the use of oxygen is more logical and more efficacious. Oxygen is indicated when there is cyanosis of the nail beds, when the pulse rate is over 120 per minute, when the respiratory rate is double or 36 per minute, and in the presence of delirium. For optimum results it should be used early before the respiratory mechanism is too exhausted to respond and should be used continuously. Oxygen can be given by nasal catheter, oxygen tent, or oxygen chamber.[3] The expense of installation of the oxygen chamber makes them a rarity. The tent is the method most generally used, but the catheter method can be used just as well when a tent is not available. To allay apprehension, the purpose of the tent should be explained to the patient. The optimum concentration of oxygen within the tent is about 50% and this is usually maintained by a flow of six to eight liters per minute. It is preferable to use a tent in which the carbon dioxide is absorbed by soda lime. It must be remembered that concentrations of oxygen of 70% or above long maintained will produce widespread injury to lung tissue so these higher concentrations must be avoided by frequent analysis of the air content of the tent. The adequate cooling of the gas by attention to the supply of ice in the apparatus is also imperative. If the patient is made more uncomfortable the technique is faulty.

In the home the use of the nasal catheter method is more easily applicable.[6] The apparatus necessary consists of an oxygen tank equipped with pressure and delivery gauge, a wash bottle, a nasal catheter, and sufficient rubber connecting tubing to allow the patient to turn from side to side. The wash bottle is necessary to furnish moisture and should be at least large enough to hold 400 cc. The tip of the lubricated catheter is inserted into the nose until its tip is just visible behind the soft palate. The reduction valve is adjusted to deliver from 4 to 12 liters per minute. This flow will provide an alveolar saturation of 38% to 56% of oxygen. The flow should never be sufficient to produce an unpleasant noise in the patient's throat and careful observation is made to see that swallowing of the gas into the stomach is not being done. Frequent spraying of the pharynx with alboline is necessary to prevent undue irritation. Commercial or industrial oxygen is just as efficacious as so-called "medicinal oxygen", is less expensive, and is always to be obtained wherever there is a welder or in almost any garage. The large tank containing 220 cubic feet will furnish a supply for 24 hours at a cost of approximately $5.00.[1] This method has been used extensively in the Harlem Hospital.

Points to be remembered in the use of oxygen are: its early and continued use, avoidance of concentrations above 70%, the necessity for adequate moisture and cooling, and lastly that it will cause bed clothes and other materials to burn with amazing rapidity so an open flame in the vicinity must be prohibited.

Of the various types of therapy which might be termed specific only two are to be considered. The use of quinine and its derivative optochin have not given clinical evidence of value despite their marked effects in the test tube.[5]

At the present time several investigators are using artificial pneumothorax and during the past year 197 cases were treated by this method in this country.[8] The total mortality rate for this group was 29.4% which is about the same as that of the general hospital. A close analysis of the cases though shows that it is capable of producing an artificial crisis in the same proportion of cases of unilateral lobar pneumonia regardless of the type of the causative pneumococcic infection.[8] This fact alone establishes its continued trial. Its limitations are that it must be used early, only adult unilateral pneumonia cases are suitable, it is technically difficult, and pre-existing pleural adhesions interfere with its production. More clinical data are necessary before its indications are definite and its value established.

Anti-pneumococcic serum prepared according to the method of Felton is at the present our most useful specific therapeutic agent. Up to the present time pneumococci have been separated into 32 different types according to immunological reactions.[9] Types I and II cause 2/3 of the cases of adult lobar pneumonia. Type III is much less frequently encountered. A potent anti-serum for types I, II, and VII, is available at this time. The type III causes a highly virulent infection for which there is no satisfactory anti-serum. The widespread use of anti-pneumococcic serum has been prevented by the prolonged and difficult laboratory method of typing the causative organism. Recently this difficulty has been overcome by the utilization of the Neufeld reaction for immediate typing which is available to everyone possessing a microscope.[10]

Anti-serum should be administered as early in the course of the disease as possible as the clinical evidence shows that it is most efficacious when used within the first three days. Therefore it is obvious that an early diagnosis is essential. A delay in diagnosis for two or three days is never to be justified when pneumonia is suspicioned.

As the serum is prepared from immunized horses the patient should be carefully questioned concerning previous injections of horse serum such as tetanus and diphtheria[12] antitoxin as well as a past history of asthma, hay fever, and hives. In this class of patients serum reactions are more frequent. Even in the absence of a definite allergic history or previous injections of horse serum a test for sensitivity should be made. A drop of the anti-serum diluted 1.10 with saline placed in the eye will produce a transitory redness and inflammation of the conjunctiva if sensitivity exists; or a small portion of the diluted serum injected intracutaneously will indicate sensitivity by the resulting wheal surrounded by an erythematous area. When no sensitivity exists as shown by either of the above tests the serum can safely be injected intravenously. It should be warmed to body temperature and injected slowly. The total dosage is governed by the clinical results and usually 100,000-200,000 units are required. It is wise to begin with a dose of 10,000 units followed in one hour by 20,000 units. This latter dose is then repeated at 4-8 hour intervals until the temperature, pulse, and respiratory rates approach normal. The temperature should be taken every two hours during this period. An artificial crisis usually results as manifested by profuse sweating, change of temperature to normal and definite clinical improvement. The chest examination will reveal evidences of pathology such as impaired percussion, resonance, and showers of moist rales for three or four days after the artificial crisis has occurred. A return of the temperature to 102 or more calls for a continuation of the serum. The commercial serum has recently been highly refined and concentrated so that reactions from its use are rare and seldom severe.

If the patient is sensitive to the serum as indicated by one of the above described tests, the serum need not be withheld, but especial care in the administration is necessary. Desensitization may be carried out by injecting small doses at half-hour intervals beginning with 1/10 cc. and doubling the dose each time until 3 cc. has been given. After that amount has been safely given the remainder of the 10,000 unit dose is injected slowly and the following doses continued as outlined for the nonsensitive patient. It is wise to have a syringe containing adrenalin available and the injection of 1 cc. is done immediately if a reaction occurs as indicated by dyspnea, constriction or pain in the chest, cyanosis, or asthmatic wheezing. Reactions from the serum are seen both early and late. The so-called[11] "thermal reaction" usually occurs within 30 minutes to an hour after injecting the first dose and is manifested by a chill and rise in temperature. It is similar to the reaction following injection of any foreign protein and has no bearing upon

the sensitivity of the individual and does not contra-indicate further injections. Seven to fourteen days after serum therapy serum sickness may result. The patient should be forewarned of this occurrence so that he will not be unduly alarmed. Usually it is manifested by a rise in temperature, a blotchy erythematous rash, swollen red, painful joints, and gastro-intestinal symptoms. This condition is seldom long continued and responds to adrenalin and calcium by mouth. One must be on guard that this elevation in temperature is not attributed to serum sickness until a careful search for complications[14] has been made. The lungs and pleural cavity should be carefully examined to rule out fluid collections and a new pneumococcic focus; the heart examined for an early pericarditis; and the nervous system for a beginning meningitis.

The results from serum therapy are often dramatic and the mortality rate has been reduced 50% by its use.

In late cases showing a positive blood culture, anti-serum should be used as an invasion of the blood stream indicates poor body defenses. Of course an artificial crisis is not to be expected but complications and an overwhelming infection may be prevented.

To summarize the main points in serum therapy are: its use early in cases accurately diagnosed and caused by pneumococci of type I, II, and VII; its careful use in individuals sensitive to horse serums; it should be warm and injected slowly; an injection of 20,000 units every 4-8 hours until a clinical improvement results regardless of the total dosage; and late in cases showing positive blood cultures.

Among the complications of lobar pneumonia empyema is perhaps most frequent. Here again careful diagnosis is essential. Frequently an x-ray of the chest is required to rule it out and all cases not showing a drop in temperature and respiratory rate at the usual time for recovery should be suspected as having this complication. Its treatment is surgical and should not be postponed. Pericarditis, endocarditis, and meningitis are usually fatal and treatment is of no benefit. Fortunately they are rarely seen. Lung abscess usually occurs when some organism other than the pneumococcus is responsible for the pneumonia. In recent years, acute nephritis has been found to be a more frequent complication than was once suspected.[12] Its treatment is similar to that of acute nephritis from other causes. A urine analysis every two days during the course of the disease will prevent its being overlooked.

In conclusion to summarize the principles of conservative management of acute lobar pneumonia main reliance is placed upon early diagnosis, rest both physical and mental, good nursing, oxygen, serum therapy if the type of pneumococci will allow, only those drugs which are definitely indicated, and careful watching and prompt action in respiratory and circulatory weakness.

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COMMONSENSE OBSTETRICS*

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In attempting to decide on a subject for a paper that would appeal to the members of this Society, I was reminded of a paper read before the Polk County Society recently. This paper dealt with the care of the newborn infant, and to me its value was far-reaching, mainly because of the simplicity and common sense methods suggested therein. It is my desire tonight to simply review some of the basic fundamentals that confront us in our obstetrical cases, knowing that they are familiar to all of us, but feeling that to freshen the memory will do no harm.

We will divide this subject into three parts, the care of the patient from early pregnancy to

*Read before the DeSoto-Hardee-Highlands County Medical Society, June, 1934.

the time labor sets in; second, the period of labor; and third, post-partum care.

The instructions that we give the patient when she first presents herself for treatment as an expectant mother are so simple and have become so fixed in our minds that there is a chance we will not put the stress on them that they should have. We may feel that the average lay-woman knows that she should watch for swelling of the ankles and face, for obstinate constipation, for unusual vaginal bleeding, and for the evidences of pre-eclamptic toxemia that are so evident to the practitioner, but if she has specific instructions from her doctor what to eat, and what to avoid eating, what exercise is advisable and also what signs of approaching complications to watch for, she will be far more apt to follow these instructions than if she is only told to "take care of yourself and let me know if you don't get along all right." She will also have more confidence in her doctor, will proceed through pregnancy with more confidence in herself, because she is following her doctor's explicit directions, and she will undoubtedly come to labor in a better physical condition. The best plan is for practitioner to supply himself with printed instructions to be given the patient, containing the following information: first, regulation of the bowels telling what you want the patient to use for this purpose: mild laxatives such as milk of magnesia and cascara are best so long as they are efficacious and then an occasional dose of calomel is often beneficial. Second, regular exercise is essential, but the patient should be warned against any tiring efforts, either too much house work or too much out-door exercise. Third, instructions should be given as to reporting to you at regular intervals for examinations and bringing the morning specimen of urine each time. Once a month these visits to the office should be made until the end of the seventh month, and then every two weeks. Fourth, give instructions as to the diet. Unless the patient be overweight and of the build that we recognize as a potential eclamptic or at least a "toxemia build," it is not essential to follow a strict diet. However, instructions should always be given to avoid overeating and also to avoid rich, heavy foods. Last, the patient should be instructed to notify her doctor if any of the following symptoms be observed: swelling of the ankles or face, any marked diminution in the output of urine, persistent headaches, spots before the eyes or any impairment of vision, constipation that does not respond to the drugs mentioned, nausea and vomiting during the last three months of pregnancy, and if any vaginal bleeding occurs. I believe that written instructions such as these are very valuable to the doctor and to the patient.

On the importance of a complete physical examination, I do not feel that there is any need to elaborate. It is important and we all know it. The pelvic measurements should be taken, especially in primiparae or when there is a history of previous abnormal courses of labor. To obtain from the patient a history of all previous pregnancies as well as of other illnesses will often disclose valuable information.

With this common-sense management of the case up to this point we will be able to bring our patients to term in good condition when no complications arise and if complications do arise we will have noted them so as to be prepared. The practitioner may approach a delivery in a satisfying frame of mind when he knows that the condition of his patient is what it should be and also that he is familiar with the position of the baby which is to be delivered.

The tendency for the practitioner to interfere with the normal course of labor is often increased by nervous, over-anxious husbands and relatives, and also by the patient herself, whom we have all had make the statement: "Doctor, I am completely worn out; I cannot have another pain and I will die if you don't do something to help me." We must remember the danger of infection from vaginal and intra-uterine manipulations, the danger of uterine rupture from the too early use of pituitary extract, and the danger to the mother and baby from the promiscuous use of forceps, especially before we have a well dilated cervix.

The indications for interference with the normal course of labor are of two types: first, we have those cases that are completely exhausted from a long period of labor, or where there is enough disproportion between the bony pelvis and the oncoming head, or where there is a brow or persistent occiput-posterior presentation, in which cases we know that we are justified in manually aiding the cervix to dilate, and to use forceps or do a version. But in a large percentage of cases that at first appear to fall in one of these classifications we will be able to obtain a spontaneous delivery if the patient can be given a period of rest by the use of morphine sulphate,

grs. one-sixth given in two cc. of magnesium sulphate.

The second type of case demanding interference is an entirely different class and presents the real emergency of an obstetrical practice. Under this head come the eclamptics and those cases wherein uterine hemorrhage developed during the latter months of pregnancy. All of these patients demand interference and demand it urgently. They must be delivered as quickly as possible and the method of interference has to be selected to suit the case, the surroundings, and the available facilities. A primipara in eclampsia, who has had no pains or not enough to dilate the cervix, should be delivered by a cesarean section, if it is possible to get her to a hospital. Otherwise, manual dilatation and a version probably will offer the quickest method. This latter method of delivery can usually be applied to the multiparous eclamptics. The best treatment of eclampsia is for us not to have it, which means proper pre-natal management. However, we do still see cases of it, almost always in patients who have failed to avail themselves of any medical attention during their pregnancy.

The most extreme emergency that we have to deal with is a placenta praevia or a premature separation of the placenta. This fact was very impressively brought to my attention during the preparation of this paper. A patient was admitted to the hospital from a town twenty miles away. Her chief complaint was uterine hemorrhage, which had been present for thirty-six hours. She was the mother of eight children, with no abnormal obstetrical history whatsoever connected with these previous deliveries. The patient was in extreme shock when admitted, being practically pulseless. She was taken immediately to the delivery room, where she was anesthetized and delivery instigated. Examination revealed the cervix to be dilated to the size of a fifty-cent piece, with the head presenting. A podalic version was accomplished after manual dilatation of the cervix, and delivery was complete in about twenty minutes. The placenta delivered with the dead baby showed a complete premature separation. Hemorrhage continued to be severe during delivery and pituitrin given afterwards did not check it materially. The patient lived less than half an hour after the delivery. It is too bad that this woman was allowed to bleed for thirty-six hours before it was decided that she presented enough of an emergency to require hospitalization. It is this type of case that demands immediate interference and even then our mortality rates are high.

The amount of anxiety with which we view the treatment of our patient after delivery depends partly on the manner in which the case was handled up to labor and more so on the management during labor and the delivery itself. The patient who has had proper prenatal care and comes to term with no toxic symptoms, relieves our mind as regards treating the nephritis that accompanies these toxemias and that can be very troublesome to clear up after delivery. In cases of this type we have all seen instances of albuminuric retinitis, which more often than not leave permanent damage and sight impairment. Then, in considering the causes that may arise during the course of labor, for a stormy post-partum, it is obvious that the patient who has had nothing but frequent rectal examinations, and no vaginal manipulations, delivers spontaneously, and passes the placenta without manual extraction, is going to cause us much less anxiety than the one who has to be delivered by one of the methods already referred to, or one who is examined vaginally too frequently and manipulated to rush delivery through instead of giving enough time for a spontaneous, natural course. When these unnatural methods are used we always lay ourselves liable to a troublesome post-partum infection.

I do not think it would be amiss to mention a few measures that will add to the comfort of the delivered patient. They reach this stage thoroughly exhausted and anything that will make them more comfortable and give them their much-needed rest, will cause them to greet their doctor with a brighter smile when he makes his next call.

The patient should lie quiet for an hour following delivery—if in a hospital, on the delivery table without being moved back to her room, and if at home she should be wrapped to prevent her taking cold, and the bed not cleaned until after an hour's quiet rest. When we have ascertained that the fundus is well contracted and no further trouble that would disturb her is anticipated, and the patient has been prepared for her night's rest, codeine and aspirin may be needed for sleep and I think that we should not hesitate to give it. After the first few hours the patient should be allowed to turn on her sides instead of being told to stay in one position, flat on her

back, unless there is a third degree laceration. After the third day the patient lying flat on her abdomen for fifteen-minute periods, several times a day, will aid in the fundus resuming its normal position, and later the knee-chest position is valuable for the same reason. Another feature of post-partum care is attention to the bowels. Most of these patients have hemorrhoids following child birth, and the milder laxatives should be used as they cause less discomfort in the presence of hemorrhoids. Local applications of ice and lubricants will also add to the comfort of your patient.

The patient should not be dismissed from her doctor's care until six weeks after delivery, at which time a pelvic examination is necessary to determine the presence of any cervical tears or perineal relaxation.

A STATISTICAL STUDY OF ACUTE APPENDICITIS*

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The material covered in this study was obtained from the records of the Duval County Hospital, Jacksonville, Florida, covering the years 1932-35 inclusive. During these four years 233 cases were admitted to the hospital with the diagnosis of acute appendicitis, and represent an average of approximately one and one-tenth case per week. The majority of these cases were operated upon, and those included in this series are those which proved to have definite appendiceal pathology as shown by the pathologist's report. Cases in which appendectomies were done incidental to other operations, and those cases in which were found no appendiceal pathology at operation, were excluded.

No attempt is made in this paper to review the signs and symptoms of appendicitis, these being well known to practically every physician. It is the general practitioner who usually first sees cases of appendicitis, and it is hoped that this statistical analysis will stress the importance of early diagnosis and prompt intervention. This is perhaps a hackneyed subject, but, considering the death of 20,000 people each year from appendicitis, and the fact that the mortality rate has not been reduced appreciably in the past twenty years, despite the modern methods of diagnosis and the more modern surgical technique, there seems adequate reason for reviewing the disease again.

The average age of this group of 233 was 26.4 years. A more detailed observation of the ages involved reveals that the youngest was six weeks old, and the oldest 69 years, with the following subgroups: nine cases were below the age of ten years; seventy-three cases were between the ages of ten and twenty years; sixty cases between twenty and thirty years; fifty cases between thirty and forty years; twenty-three cases between forty and fifty years; sixteen cases between fifty and sixty years; and two cases over sixty years of age. It might be mentioned as a matter of interest that the six weeks old infant was in the hospital undergoing treatment for a congenital anemia when it suddenly developed constant vomiting and a distended abdomen, and died within six hours. Autopsy revealed a gangrenous appendix, from torsion, with generalized peritonitis.

Of the entire series of cases, 147 were white, 88 were colored; 157 were males, and 76 were females. The diagnosis of appendicitis, as a rule, is easier to make in males because of the ever-present question of acute salpingitis in the female, especially in the type of patients seen at a charity institution. One should ever keep the differential diagnosis in mind.

A quarterly tabulation of the cases show that during the first three months of the years 42 cases were seen; during the second quarters 68 cases were seen; in the third quarters 60 cases; and in the final quarters 63 cases were seen. These figures represent the total number of cases of each quarter for all of the four years.

One of the most important considerations in any attempt to explain the number of deaths from appendicitis is the duration of the disease from the time of onset until operation. The average duration in this series was 2.7 days. This length of time would be inexcusable in private practice, but in a charity hospital patients are taken in when they apply for treatment or when they are referred to the hospital by a physician who sees them at home. Sixty-nine cases were operated upon within twenty-four hours of the onset; 61 within forty-eight hours; 28 within three days; 18 within four days; 10 within five days; 5 after six days; 3 after seven days; 2 after eight days; 4 after ten days; 3 after fourteen days; 1 after fifteen days; and 1 case was operated upon sixty days after the onset of

*Read before the Nov. 1935 Staff meeting of the Duval County Hospital, Jacksonville.

the symptoms. This latter patient had a well walled-off appendiceal abscess and made an uneventful recovery following drainage. The application of an ice cap to the abdomen tends to prolong the interval between onset and operation in that it often alleviates the pain. This may be considered as a harmful procedure because cold applications mask the symptoms of pain but fails to stop the progress of the disease itself, which, under such treatment, often extends to a condition of acute peritonitis. The delay in repeating leukocyte and differential counts often permit time for complications to develop. Early operation before complications develop is especially important in elderly people, obese patients, and children since these groups of people succumb readily to peritonitis.

The habit of giving cathartics for any and all instances of stomach ache of vague origin account in no small way for the continued high mortality from acute appendicitis. If the public could be made to realize that all pain in the abdomen cannot be remedied across the drug store counter with a dose of castor oil, or a dose of salts from the family medicine cabinet, it is believed that the mortality would show a marked decrease. In the present series, it was definitely determined that 54, or twenty-three per cent, of the patients had taken a cathartic of some sort after the onset of the illness. This question was not brought out in all of the records examined. If the point had been definitely recorded in every case, we feel sure that the percentage would have been even higher. Of the 54 cases that did give the history of having had a cathartic, 31 were found to have ruptured appendices, and in these 31 cases there were 12 deaths. The inference is clear. Brooks points out that the persistently high death rate from appendicitis is largely due to meddlesome treatment advised by relatives or used by patients themselves for abdominal pain. Cathartics given several hours after the onset of the attack are even more dangerous than those taken earlier, since the appendix is then distended and friable and a local peritonitis is rapidly transformed into a diffuse peritonitis.

The mortality in this group of patients was seventeen and six-tenths per cent, or 41 deaths. As far as can be determined the average mortality over the entire country is around twenty per cent, and the figures obtained here are comparable to those of other clinics. Of the deaths, 30 were ascribed to peritonitis; 2 to post-operative pneumonia; 2 to tuberculosis in which the appendicitis was an incidental complication; 2 patients died from intestinal obstruction and 1 from postoperative ileus; 1 was found to have multiple abscesses of the abdomen, gumma of the liver, and tuberculosis of the pleura; 1 died from extensive sloughing, toxemia and terminal pneumonia; and in one case it was assumed, in the absence of permission for an autopsy, that the patient had typhoid fever. One patient died following the administration of a spinal anesthetic. A comparison of the above figures with those of the preceding paragraph further emphasizes the danger of giving cathartics unwisely.

Of the patients operated upon, 191, or eighty-two per cent, were found to have unmistakable acute appendicitis grossly. The others were diagnoses of chronic, catarrhal, etc., appendices. Eighty-eight, or thirty-eight per cent, were found ruptured. Thus it is seen that in over a third of the cases of rupture, there was a history of having had a cathartic. Twelve and a half per cent, or 29 patients, were found to have a localized abscess, and twenty-four per cent, or 56, had generalized peritonitis. In ninety-two, or thirty-nine per cent, of the cases, drainage was instituted following operation. It may be mentioned here that proper attention should be paid the insertion of drains. The one death from extensive sloughing of the abdomen, back and thigh, was the direct result of sutures being placed too closely around a rubber dam drain, preventing adequate drainage.

The question of when to operate following a delay after the onset of an acute attack is always a difficult one and should never be considered lightly. An appendicitis may resolve, or it may go on to form a local peritonitis which, if disturbed by inopportune operation, would rapidly become a diffuse peritonitis. The local peritonitis, if undisturbed, will tend to form an abscess which may itself resolve, or later may be drained with comparative safety. There is never any question as to the wisdom of operating in a case of general peritonitis. In three of the cases of this series there was a general peri-

tonitis at the time of operation and the patients expired on the operating table. There is a fine distinction to be made in the treatment of ruptured appendices, and the time element plays a most important part in this distinction. In general it is deemed advisable to withhold operation on patients with marked distention and a temperature over 101, who have vomited and been ill for several days. Of the ruptured cases in this series treated without operation 6 died, and 2 recovered. Four of the six died before the newer method of treating ruptured appendices and peritonitis was instituted. Results obtained in this hospital, and reports received from other sources, indicate that the following therapy is efficacious in treating peritonitis. The patient is placed in Fowler's position for dependent drainage into the culdesac, and heat is applied to the abdomen. Food, drink and oral medication are withheld and adequate supportive solutions are given parenterally. Morphine, given in sufficient doses often enough to keep the patient comfortable, has been shown to favor the resolution of peritonitis by increasing the tone of the intestinal musculature, thus lessening peristalsis. The Levine tube connected with Wagensteen's duodenal suction apparatus has proven to be a most valuable adjunct to the above treatment. It effectively drains the stomach and duodenum, prevents excessive vomiting and its consequent acidosis, aids in preventing distention, and in certain cases prevents the torture of excessive thirst by allowing the patient to have sips of water, since the water is removed from the stomach as soon as it reaches there. It might be mentioned here that the Levine suction apparatus is proving adaptable to a wide variety of conditions and may be considered as one of the most valuable of recent additions to the surgeon's armamentarium. We have hopes of being able to show a decrease in the mortality of ruptured appendices in the future by the use of the above outlined method of treatment. In any case, where there is a question of whether or not to operate, a surgeon of experience and competent judgment should be called into consultation.

A white blood count and differential count were done in the majority of these cases. The average white cell count was found to be 14,918, with the highest being 34,100 and the lowest 4,200. There were 10 cases where the white cell count was below 10,000; 84 cases between 10,000 and 20,000; 18 between 20,000 and 30,000; and only 2 above 30,000. The average polymorphonuclear leukocyte count was seventy-three and three-tenths per cent, with the highest being ninety-six per cent and the lowest twenty-six per cent. Ten cases had over ninety per cent; 59 had between eighty and ninety per cent; 50 between seventy and eighty per cent; 14 between sixty and seventy per cent; 7 between fifty and sixty per cent; and only 6 cases had below fifty per cent.

SUMMARY

1. The high death rate and persistent high mortality of acute appendicitis warrants further reviewing of the disease.

2. Two hundred and thirty-three cases are reviewed, the average age being 26.4 years. The largest group of cases are found between the ages of 10 and 20 years.

3. The majority of the cases were white males.

4. The seasonal incidence does not show enough variation to be of note.

5. The delay between the onset of the attack and the operation plays a large part in maintaining the mortality. The average delay in this series was 2.7 days.

6. The habit of giving cathartic for all cases of stomach ache is the most pernicious one associated with acute appendicitis.

7. The mortality rate in this series was seventeen and six-tenths per cent, the majority of the deaths being due to peritonitis.

8. The importance of inserting drains properly is brought out.

9. The decision of whether or not to operate in delayed cases should be made by an experienced surgeon.

10. Newer therapy for peritonitis is described for the treatment of ruptured appendices.

11. A study of the WBC and PMN counts shows that they are valuable aids in diagnosing acute appendicitis.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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TEAM WORK

How often this problem comes most convincingly to our attention. Coordination of effort through the different branches and specialties in medicine becomes more urgently essential with the never ending progress and additions to medical science.

Those practicing any one of a number of special branches of medicine must have a broader comprehension of the subject of medicine than ever before. This is because the progress is not limited to one specialty but has made equal strides in every department that has to do with etiology, diagnosis and treatment of human ailments.

Whenever an obstinate problem is presented, then this coordination of the separate units or specialties must be utilized. The broader the knowledge of the first consultant, the better he will be able to coordinate the assistance to solve the problem and institute successful treatment. We should appreciate more than ever before the influence of a constitutional disease on the function of any one organ of the body. Such diseases as syphilis, tuberculosis and diabetes may produce a disturbance or a complaint most urgently in a single organ. The specialist limiting his work to that organ may fail in his diagnosis unless he has used all the available resources wisely. The specialist must not only be familiar with the essentials of his specialty, but he must have a thorough knowledge of the diagnostic measures which modern medical science has placed at his command.

CORRESPONDENCE

Quincy, Fla., Aug. 14, 1936.

To the Editor:

COMPENSATION ACT WELL ADMINISTERED

There have been so many conflicting statements made by various members of the Association relative to the Workmen's Compensation Act and the way claims are handled by the Chairman of the Florida Industrial Commission, that I feel a statement relative to the real merits of this Act and the excellent manner in which the Commission handles these claims should be set forth in the Journal for the information of the members of this Association.

Members of the various committees of the Florida Medical Association, myself included, have recommended that a physician act as an advisory member of the Board that constitutes the Florida Industrial Commission or that a physician be appointed as a member. It has also been suggested that the committee appointed by the Florida Medical Association make the recommendation. This very principle has been carried out. In fact, in all compensation cases where medico-legal advice was needed and where there has been pending litigation, the Commission has availed itself of the advice of reputable physicians as medical referees. On more than one occasion they have secured the services of two or more disinterested physicians to review the evidence submitted at these hearings and in each instance a reputable man has been called upon. In most of the cases, the physician called holds a fellowship in the American College of Surgeons, the American College of Physicians or the American Roentgen Association.

Personally, I know of one case where the Commission had the patient examined by Dr. F. Clifton Moor and Dr. B. M. Rhodes of Tallahassee and then referred the patient to Dr. F. L. Fort, orthopedic surgeon of Jacksonville, for independent examinations. After the patient had been treated by four other physicians and consultations held, another physician was called upon to act as referee.

I feel that the medical profession is most fortunate in having the Honorable Wendell C. Heaton as Chairman of the Florida Industrial

Commission and to further substantiate this statement, please note the following copy of the ruling of the Florida Industrial Commission as to recognized medical attention under the Florida Workmen's Compensation Act. I would be very glad if you would publish this in the Journal.

"Section 13(a) of the Act requires 'The Employer shall furnish medical, surgical and other attendance or remedial treatment, nursing and hospital service, medicine, crutches, and apparatus for such period as the nature of the injury or the process of recovery may require.' The intention of the legislature with reference to medical or surgical treatment is further indicated in Section 25(g) where it instructs the Commission clearly that examinations of injured employees claiming compensation shall be done 'by a duly *qualified physician.*' The word 'qualified', when embodied in such a legislative act, connotes conformity to some prevailing standard, accepted in Florida as those persons who have completed a prescribed course of study and have passed an examination by the State Board of Medical Examiners, and have been duly licensed to practice medicine. See Ch. 8415 Acts 1921 p. 2, C. G. L., 1927.

"Services of persons other than qualified physicians and surgeons to be recognized by the Industrial Commission on compensation cases must be performed under the supervision of a qualified physician or surgeon. While the term 'remedial treatment', if used without limitation, may be susceptible of a broad construction, the Act clearly indicates that those words, as therein used, are restricted to medical assistance rendered by the physician or under his direction and control.

"There are numerous schools and cults enjoying limited patronage and making divers claims of ability to alleviate pain and cure disease, whose merits it is not necessary for me to consider. When the employer, operating under this statute undertakes to provide an exponent of any such school or cult as 'qualified' and the question of qualification has to be passed upon by the Commissioner, the measure of qualification then becomes the prevailing standards of society, not the judgment or convictions of the employer however sincerely or disinterestedly exercised. While it is not without the limits of possibility that some persons or group of persons, either by reasoning or theoretical grounds, or by experimentation, or even accident, might discover a new and better method than that generally practiced and taught, such a contingency is highly improbable, and the employer under this Act who provides a practitioner of any such unusual method, contrary to the prevailing standards of society, fails to conform to the provisions of Section 13(a) of the Act.

"Since I have been asked particularly for a ruling with reference to Naturopaths and Chiropractors, it is interesting to note the definitions given by Florida Statutes; Chapter 12286 Acts of 1927 defines Naturopathy to mean the use and practice of psychological, mechanical and material health sciences to aid in purifying, cleansing, and normalization of human tissues for the preservation or restoration of health, according to the fundamental principles of anatomy, physiology and applied psycho'ogy, as may be required, provided, however, that nothing in this chapter shall be held or construed to authorize any Naturopath licensed hereunder to practice *materia medica* or *surgery* or any other treatment provided by law for the cure or prevention of disease or ailments.

"Section 3446, Compiled General Laws 1927: 'Any Chiropractor who has complied with the provisions of this chapter may adjust by hand the articulation of the spinal column but shall not prescribe or administer to any person any medicine or drug now or hereafter included in materia medica, perform any surgery except as hereinafter stated, nor practice obstetrics or osteopathy.'

"Such definitions are not construed by the Commission to mean 'qualified physicians' used in the language of Section 25(g) indicating the intent of the Legislature.

"Wendell C. Heaton, Chairman,
Florida Industrial Commission."

This interpretation of the law by Mr. Heaton would be sufficient to prove to anyone that the Chairman of this Commission is desirous of doing the right thing by the insurer, the insured and the physicians; furthermore, I believe it is a very wise decision on the part of the Commission for the medical referee in these cases not to be generally known to the profession or the insured, thereby insuring greater efficiency in adjusting these questionable cases.

Respectfully submitted,
J. C. Davis, M.D., Chairman,
Committee on Legislation and Public Policy.

EAST COAST MEDICAL MEETING NOVEMBER 13-14

The Florida East Coast Medical Association Meeting will be held this year in Fort Pierce, Florida, on Friday afternoon of November 13th and Saturday morning of the 14th. The usual entertainment features, banquets, etc., are being arranged and, of course, the ladies will be royally entertained. Those appearing on the program will be Dr. Homer Pearson, Miami, Dr. Randolph Perdue, Miami, Dr. Ludo VonMysenbug, Daytona Beach, Dr. P. B. Welch, Miami, Dr. Louis Orr, Orlando, Dr. J. S. McEwan, Orlando, Dr. H. H. Cooke, Miami, Dr. L. L. Whidden, Fort Pierce, Dr. W. W. Kirk, Jacksonville, and several others to be announced later.

With such an array of gifted speakers as these most of us should not be able to miss this meeting. Make your plans now and remember the dates, November 13th and 14th. The officers are working hard to make this one of the outstanding meetings of the year.

STATE NEWS ITEMS

Dr. O. O. Feaster, president of the Association, spent a vacation of two weeks with his family at their summer home in Highlands, North Carolina, duing the month of August.

* * *

Dr. Julius C. Davis is spending his vacation in North Carolina. He expects to return to Quincy about October 1.

* * *

At the request of Dr. Eustace Long, president of the Madison County Medical Society, a meeting was held on August 20, 1936, in Madison for the purpose of discussing proposals for a public hospital for Madison County. The following officers and members of the Florida Medical Association were in attendance:

L. M. Anderson, Lake City.
T. H. Bates, Lake City.
Herbert L. Bryans, Pensacola.
George O. Davis, Madison.
R. B. Harkness, Lake City.
W. M. Ives, Lake City.
Edward Jelks, Jacksonville.
J. K. Johnston, Tallahassee.
Eustace Long, Madison.
D. A. McKinnon, Marianna.
Henry E. Palmer, Tallahassee.
Shaler Richardson, Jacksonville.
J. S. Turberville, Century.
J. C. Vinson, Tampa.
J. Ralston Wells, Daytona Beach.
B. A. Wilkinson, Tallahassee.

* * *

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that out of 116 applicants who took the Board examination held in Jacksonville, June 15-16, twenty-two failed to make a passing grade. The successful applicants came from more than a dozen states in widely scattered parts of the country. It was the largest class in ten years to apply for medical license in Florida and indicates that the nation is looking to Florida as the State of new opportunities.

The highest average, 90.7, was made by Dr. Francis Eugene Denman, Nicholasville, Kentucky, a graduate of Louisville Medical College in 1917. The second highest average, 87.8, was made by Dr. James Voorhees Freeman of Jacksonville, a graduate of Harvard in 1936.

The following is a list of the successful applicants:

Adams, Mark Elbert, 6620 Buffalo Avenue, Jacksonville. University of Arkansas, 1936.

Alberts, Irving Lester, Passavant Hospital, Pittsburgh, Pennsylvania. Emory University, 1936.

Allan, Harry Lee, 368 4th Street, N. E., Atlanta, Georgia. Emory University, 1933.

Allen, Ralph Fred, 843 N. W. 12th Street, Miami. Tulane Medical School, 1935.

Auslander, Harold Paul, 25 Fort Washington Avenue, New York City. University of Toronto, 1935.

Austin, Theodore Roe, Greenwood, Mississippi. Vanderbilt Medical School, 1932.

Banquer, Jacob Ellis, 130 Woodcliffe Road, Newton, Massachusetts. Tufts Medical College, 1917.

Bartley, Henry Ernest (N), 1106 West 8th Street, Jacksonville. Meharry Medical College, 1935.

Bassett, Sam Ardinger, 1250 South Big Bend, St. Louis, Missouri. Washington University School of Medicine, 1931.

Bowen, Frederick Hardy, 2000 Park Street, Jacksonville. University of Virginia, 1936.

Brand, Alonzo Frederick, Fayetteville, New York. Syracuse University, 1921.

Caffee, Henry Hollis, Winter Haven. Harvard Medical School, 1935.

Calhoon, Jay Walter, Uhrichsville, Ohio. Ohio State University, 1921.

Camp, Milton Newman, care J. D. Camp, Fort Lauderdale. University of Georgia, 1936.

Cason, Hugh Bunyan, Jr., Warrenton, Georgia. Emory University, 1928.

Chambers, James Webster, Grady Hospital, Atlanta, Georgia. Emory University, 1936.

Clark, Burton, 11 Algoma Boulevard, Oshkosh, Wisconsin. Harvard Medical School, 1923.

Clark, Samuel Johns, 127 Pattens Heights, Lakeland. Emory University, 1936.

Coulter, Philip Louis, 505 DeLeon Street, Tampa. University of Cincinnati, 1912.

Denman, Francis Eugene, 117 Richmond Avenue, Nicholasville, Kentucky. University of Louisville, 1917.

Ditman, Norman Edward, 25 East 67th Street, New York City. Columbia University, 1900.

Edwards, Howard Keay, 311 Avenue Camilo, Coral Gables. Washington University, 1936.

Elarbee, Harry Moore, Pahokee. Kansas City University, 1929. (Special work taken at Emory 1935-6.)

Engelking, Charles Ferdinand, U. S. Marine Hospital, New Orleans, Louisiana. University of Texas, 1935.

Exley, David Wuest, Kings County Hospital, Brooklyn, New York. Cincinnati University, 1935.

Fort, Chester Arthur, Jr., Ocala. Tulane Medical School, 1936.

Franckle, Cornelius Shaw, Hotel Alexander, St. Petersburg. Harvard Medical School, 1933.

Freeman, James Voorhees, 2005 Park Street, Jacksonville. Harvard Medical School, 1936.

Garner, John Patterson, 1559 Peachtree Street, Apartment A-5, Atlanta, Georgia. University of Georgia, 1934.

Gatti, William John, 424 East Mahoning Street, Punxsutawney, Pennsylvania. Baltimore College of Physicians and Surgeons, 1914.

Googe, James Turner, Jacksonville. University of Tennessee, 1911.

Gray, Wilson Carney, Charity Hospital, New Orleans, Louisiana. Louisiana State University Medical Center, 1936.

Hagood, John Dan, 300 Jeffords Street, Clearwater. University of Tennessee, 1932.

Haltom, William Lorenz, Duke Hospital, Durham, North Carolina. Duke University, 1932.

Harper, Harry Taylor, Jr., 3111 Piedmont Road, Atlanta, Georgia. Emory University, 1933.

Hart, Benjamin Franklin, Zephyrhills. Rush Medical College, 1934.

Hatch, John Augustus, 109 East Main Street, Penn Yan, New York. Buffalo Medical School, 1919.

Hatfield, John Richard, 315 East Pine Street, Orlando. University of Tennessee, 1935.

Holloway, Charles Edward, 269 Moreland Avenue, N. E., Atlanta, Georgia. Emory University, 1936.

Hood, Jennings Sudler, 90 Owen Avenue, Lansdowne, Pennsylvania. University of Pennsylvania, 1933.

Howdon, William Martin, 505 North Fort Harrison Avenue, Clearwater. Tulane University, 1936.

Humphreys, Jack, Moultrie, Georgia. University of Georgia, 1936.

Huskey, Aubrey Layton, State Hospital, Chattahoochee. Tulane University, 1932.

Irwin, Thomas Melbourne, 2064 Park Street, Jacksonville. Tulane University, 1936.

Jack, Ralph Willis, Farmville, Virginia. Johns Hopkins Medical School, 1930.

Jefferson, Curtis Benjamin, 246 Hyde Park Avenue, Tampa. Johns Hopkins Medical School, 1936.

Jennings, John Leonard, Jr., Tampa Municipal Hospital, Tampa. Medical College of Virginia, 1934.

Jennings, William Logan, Jennings. Tulane Medical School, 1936.

Kauders, Ferdinand Hoffman, Dade County Hospital, Miami. University of Georgia, 1935.

Kennedy, William Charles, 2206 Park Avenue, Miami Beach. Columbia University, 1928.

Knowles, Hal Simpson, Box 466, Leesburg. Rush Medical College, 1936.

Krichbaum, Franklin Maurer, 504 Third Street, N. W., New Philadelphia, Ohio. Western Reserve University, 1935.

Kuhnert, Tom Hedrick, Jackson Memorial Hospital, Miami. University of Tennessee, 1935.

Lamson, Theodore, 93 Grand Avenue, Freeport, New York. Johns Hopkins University, 1901.

Leonard, George Nelson, 1 Central Avenue, Lawrence, New York. Albany Medical College, 1919.

Lewis, Albert W., Jr., Grady Hospital, Atlanta, Georgia. University of Tennessee, 1932.

Longenecker, Charles Rea, 1330 Sixth Avenue, Apartment 3-C, New York City. Johns Hopkins University, 1932.

Maloney, Frank George Hiram, Ironwood, Michigan. Toronto University, 1924.

Marks, Meyer Benjamin, Cook County Hospital, Chicago, Illinois. University of Illinois, 1934.

Massey, James Lloyd, Quincy. Tulane University, 1936.

McClary, George Robin, 659 N. W. 47th Street, Miami. University of Tennessee, 1936.

McPhaul, Wilbur Ashley, 2nd and Julia Streets, Jacksonville. University of Nashville, 1904.

Mendel, James Harold, Germantown Professional Building, Philadelphia, Pennsylvania. Jefferson Medical College, 1918.

Mitchell, John Thornton, 2335 West Flagler Street, Miami. University of Tennessee, 1936.

Mizell, Von DeLaney (N), Dania. Meharry Medical College, 1936.

O'Neal, James Talton, St. Luke's Hospital, Jacksonville. Medical College of Virginia, 1935.

Parsons, Hugh Earle, 207 Memorial Highway, Tampa. Tulane Medical School, 1936.

Patton, Sherrel David, Tampa Municipal Hospital, Tampa. University of Arkansas, 1935.

Pearson, Julius Ralph, Jackson Memorial Hospital, Miami. Jefferson Medical College, 1932.

Pendino, Joseph Achilles, 3410 Almeria Avenue, Tampa. South Carolina Medical State College, 1936.

Portier, Rodney Haresurt (N), 348 N. W. 7th Street, Miami. Meharry Medical College, 1935.

Ralston, Raymond Hamilton, Slippery Rock, Pennsylvania. Duke University, 1934.

Ramsay, Frank Lewis, Jackson Memorial Hospital, Miami. University of Tennessee, 1935.

Reed, Philip Byron, 1750 Second Avenue, North, St. Petersburg. Indiana University, 1930.

Robbins, Bernard Louis, 2706 Ridgewood Avenue, Tampa. New York Homeopathic Medical College and Flower Hospital, 1934.

Rowell, John Putnam, Box 980, St. Petersburg. University of Cincinnati, 1936.

Short, Calvin Horner, 330 Cadima Avenue, Coral Gables. Rush Medical College, 1929.

Silsby, Harry Zettlemeyer, New Smyrna. Louisiana State University Medical Center, 1935.

Smith, Donald William, 621 Douglas Road, Miami. Tulane Medical School, 1933.

Snyder, Frank Leslie, Jackson Memorial Hospital, Miami. Ohio State University, 1935.

Stead, Vergil Giles, 211 North Albany, Apartment 4, Tampa. University of Louisville, 1935.

Stephens, Edgar Walter, Jr., Emory University Hospital, Atlanta. Emory University, 1936.

Stover, Richard Frederick, 201 West Minnesota Avenue, DeLand. Indiana University, 1935.

Teasley, Benager Columbus, Jr., Grady Hospital, Atlanta, Georgia. Emory University, 1936.

Thomas, Harold Rudolph, Tampa Municipal Hospital, Tampa. Baylor Medical College, 1934.

Thomas, John Henry, Jackson Memorial Hospital, Miami. Jefferson Medical College, 1935.

Thomas, Robert Yates Hayne, Jr., 504 Lynch Building, Jacksonville. Temple University of Philadelphia, 1935.

Tippins, Henry Lester, 240 Iver Street, R. F. D. 5, Box 146, Jacksonville. Atlanta College of Physicians and Surgeons, 1913. (Now Emory.)

Turberville, John Killiebrew, Century. Tulane University, 1935.

Wandeck, William Roy, State Hospital, Chattahoochee. Emory University, 1933.

Ward, Albert Lee, Pensacola Hospital, Pensacola. Tulane University, 1936.

Weinreb, Joseph, St. Luke's Hospital, Jacksonville. Vanderbilt University, 1935.

Wilson, Ira, Key West. University of Minnesota, 1934.

Young, Clifton Aurelius, U. S. Naval Air Station, Pensacola. Jefferson Medical College, 1923.

HENRY MATTOX STRICKLAND

The passing of Dr. Henry M. Strickland on July 1, 1936, brought a personal grief to many residents of Live Oak and the surrounding territory with whom he had shared joy and sorrow for twenty-six years. Doctor Strickland's practice was wide and his friends many.

Henry Mattox Strickland was born at Reidsville, Georgia, on August 5, 1886. He secured his medical education at the Hospital Medical College of Atlanta, from which he graduated in 1910. Shortly following his graduation, he was married to Miss Ruby Jordon of Live Oak. Doctor Strickland practiced in Jacksonville for a few months but in November of the same year, he took his bride to Live Oak where they made their permanent home.

Doctor Strickland was prominent in professional and fraternal circles in his community. He served as secretary of the former Suwannee County Medical Society, was a life member of the Morocco Temple and a Shriner.

Surviving him are his widow; a daughter, Mrs. H. H. Hair, Jr., of Live Oak; and a grandson, Henry Mattox III. A son, Henry Mattox, Jr., died in April, 1935, at the age of 18 years.

Dr. and Mrs. Carl D. Hoffmann of Orlando sailed recently on the Manhattan for a two months' trip in Europe. This will be a combined vacation and study trip as Doctor Hoffmann will attend a number of clinics.

* * *

Dr. Grover C. Freeman of Lakeland has returned from Chicago where he took post-graduate work in electrocardiography and clinical heart disease at the Cook County Hospital. He has recently purchased new equipment, including an electrocardiograph for complete diagnostic service..

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Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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The Sixteenth session of the Southern Pediatric Seminar, held at Saluda, North Carolina, July 20 through August 1, was attended by fifty doctors from the southern states. Nine doctors were in attendance from Florida, giving this state the largest representation.

Able lectures were given by Dr. W. A. Mulherin, Augusta, Georgia, dean of the Seminar; Dr. Horton Casparis of Nashville, Tenn.; Dr. Charles J. Bloom of New Orleans, La.; Dr. W. L. Funkhouser, Atlanta, Ga.; and others who stand high as pediatricians in the South. The Spartanburg Baby Hospital, sponsored by Duke University, which is open at Saluda from June 1 until October 1 of each year in connection with Dr. D. L. Smith's Children's Sanatorium, furnished some very interesting clinics. These clinics were conducted by Dr. Sam Ravenel of Greensboro; Dr. Angus McBryde of Duke University, Durham, N. C., and Dr. Francis B. Johnson of Charleston.

Dr. J. T. Denton of Sanford, Florida, who attended the Seminar for the sixth year, was chosen class president. Other doctors who attended from this state were: F. W. Bartleson, Ft. Myers; K. M. Davis, Delray Beach; H. T. Fenn, Mt. Dora; Robbins Nettles, Clearwater; W. C. Pay, DeLand; W. F. Peacock, Bartow; and E. B. Woods, Jacksonville.

The Seminar, which is held each summer is, indeed, a worthwhile post-graduate course in methods of diagnosis, prevention and treatment of diseases of children and those who attended were well satisfied with the work accomplished.

* * *

President O. O. Feaster was guest speaker at the July meeting of the Dade County Medical Society. In his discourse, he brought out very forcibly many of the vital economic problems which at present confront the medical profession.

* * *

The revised constitution and by-laws will be published in the November Journal. In this reproduction of the constitution and by-laws will be found a Florida outline map showing, geographically, the committee districts and the councilor districts. There will also be a table shown, listing the names of the counties in each of the various districts. Reprints of the revised constitution and by-laws have been run off in booklet form and will be mailed to any member of the Association upon request.

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Dr. Carlos P. Lamar of Miami spent the month of August at the Mayo Clinic doing post-graduate work. He also visited the Johns Hopkins University at Baltimore and the Massachusetts General Hospital at Boston. He also spent some time at the headquarters of the American Medical Association in Chicago where he conferred with the officials of the Association's Committee on Medical Economics.

* * *

Dr. and Mrs. Paul K. Jenkins of Miami Beach, accompanied by their children, Paul, Jr., Ruth, Mary and Salley, have returned from a two-months' 14,000-mile automobile trip to the far west, including cities in Canada and Mexico. Classmates in St. Louis and friends in Seattle, Salt Lake City, Los Angeles and New Orleans were visited, and trips to twelve national parks and to the expositions at San Diego, Ft. Worth and Dallas, were included in their itinerary.

* * *

Dr. W. Terrell Simpson and family of Winter Haven have returned from a six weeks' vacation spent in the mid-west. Doctor Simpson took advantage of this opportunity to spend some time at the Mayo Clinic in Rochester, Minn.

COMPONENT COUNTY SOCIETIES

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Arcadia House, Arcadia, August 11. Members present were: G. F. Highsmith, C. H. Kirkpatrick, G. H. McSwain and J. A. Simmons of Arcadia and L. W. Martin and H. V. Weems of Sebring. Drs. M. J. Alexander of Punta Gorda and T. F. McDaniel of Sebring were visitors at this meeting. At the business meeting, the Board of Censors reported favorably on the application for membership of Dr. T. F. McDaniel and it was passed by the Society. The scientific program consisted of two papers: "The Right Side of the Abdomen and Its Contents", by Dr. G. F. Highsmith, and "Hirschprung's Disease", by Dr. L. W. Martin. It was voted to hold the September meeting at Avon Park.

* * *

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held a dinner meeting at the Shrine Club, St. Petersburg on August 21. The principal speaker was Dr. A. J. Wood, who chose as his subject, "Progress in Medicine."



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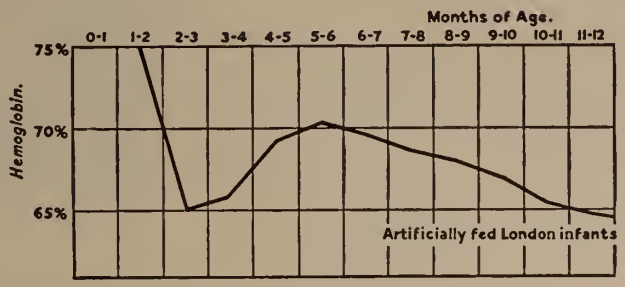
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2. During this period the infant's diet contains very little iron—1.44 mg. per day from the average bottle formulae of 20 ounces, or possibly 1.7 mg. per day from 28 ounces of breast milk. (Holt.[3])

For these reasons, and also because of the low hemoglobin values so frequent among pregnant and nursing mothers (Coons,[4] Galloway[5]), the pediatric trend is constantly toward the addition of iron-containing foods at an earlier age, as early as the third or fourth month. (Blatt,[6] Glazier,[7] Lynch[8].)

The Choice of the Iron-Containing Food

1. Many foods reputed to be high in iron actually add very few milligrams to the diet because much of the iron is lost in cooking or because the amount fed is necessarily small or because the food has a high percentage of water. Strained spinach, for instance, contains only 1 to 1.4 mg. of iron per 100 gm. (Bridges.[9])

2. To be effective, food iron should be in soluble form. Some foods fairly high in total iron are low in soluble iron. (Summerfeldt.[10])

3. **Pablum is high both in total iron (30 mg. per 100 gm.) and soluble iron (7.8 mg. per 100 gm.) and can be fed in significant amounts without digestive upsets as early as the third month, before the initial store of iron in the liver is depleted. Pablum also forms an iron-valuable addition to the diet of pregnant and nursing mothers.**

Pablum (Mead's Cereal thoroughly cooked and dried) consists of wheatmeal, oatmeal, cornmeal, wheat embryo, brewers' yeast, alfalfa leaf, beef bone, iron salt and sodium chloride.

[1-10] Bibliography on request.

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Reports Given at Auxiliary Luncheon, Orange County

Dr. Meredith Mallory, delegate from Florida to the recent convention of the American Medical Association in Kansas City, gave a report of the convention to members of the Auxiliary of Orange County Medical Society at their recent monthly luncheon.

Mrs. Henry Spiers, president of the auxiliary, gave a report of the auxiliary sessions of the Florida Medical Association convention cruise to Cuba.

Mrs. S. L. Ricker was appointed program chairman for the coming year, and Mrs. Charles Collins, chairman of public relations.

Attending the luncheon were Mrs. Carl D. Hoffmann, Mrs. L. C. Ingram, Mrs. C. D. Christ, Mrs. S. L. Ricker, Mrs. Eugene Jewett, Mrs. Tayloe Gwathmey, Mrs. Charles Collins, Mrs. Spencer Folsom, Mrs. Frank Gray, Mrs. J. A. Pines, Mrs. W. H. Spiers.

Mrs. Christ asked the auxiliary as a unit to become a member of the Orlando-Winter Park branch of the Needlework Guild to contribute articles to be used by the County Nurse.

The following members were elected to office:

Mrs. W. H. Spiers, 36 W. Copeland, President.

Mrs. Carl D. Hoffmann, 503 Florida, First Vice-President.

Mrs. Charles J. Collins, 219 Copeland, Second Vice-President.

Mrs. E. L. Jewett, 11 Lucerne Circle, Recording Secretary.

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Delegates to the state meeting: Mrs. Frank Gray, Mrs. C. J. Collins.

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The ketogenic diet, introduced by Clark and Helmholz, of the Mayo Clinic, in 1931, has been highly successful in the treatment of certain types of infection of the urinary tract.

Variations in tolerance among different patients to this diet and the impossibility of sufficiently reducing the pH of the urine in some patients have led to research for an adjunct to this treatment which would enhance the efficacy of the diet and reduce disturbing side-reactions.

Among the drugs now being studied for this purpose, mandelic acid has proved highly beneficial in a carefully controlled clinical series of cases. Originally introduced by Rosenheim, it has been used both as the sodium salt (sodium mandelate), combined with the administration of ammonium chloride, and as ammonium mandelate, obviating the simultaneous administration of ammonium chloride in many cases.

We are reliably informed that the Lilly Research Laboratories are co-operating with a limited number of clinical groups in the study of this new agent for increasing urinary acidity and the bacteriostatic and bactericidal power of the urine. In many cases it has been found unnecessary to continue the ketogenic diet in view of the beneficial results which can be obtained by the use of ammonium mandelate alone.

Summary of August Issue of Borden Digest

The value of irradiated and metabolized vitamin D milks as prophylactics against rickets is demonstrated by the clinical study reported in Abstract No. 82.

Recent studies showing that the superior effectiveness of irradiated vitamin D milk may be due to the association of the vitamin with the lactalbumin of the milk are discussed in the editorial presented in Abstract No. 83.

The influence of vitamin D on child health and development is described in Abstract No. 84, in which the possible relationship between a decrease in rickets and an increase in the consumption of fluid and evaporated vitamin D milk is pointed out.

A warning against the use of deteriorated cod

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liver oil is given in the article which is the basis of Abstract No. 85.

Certified milk, evaporated milk and dried milks such as Dryco and Klim, are recommended for infant feeding in the material reviewed in Abstract No. 86.

Pasteurization of all milk supplies is strongly advocated in the editorial outlined in Abstract No. 87.

The effects of excessive carbohydrate on bacteria causing dental caries and discussed in Abstract No. 88, in which attention is called to the fact that ingestion of acidophilus bacteria has no relation to the organisms which are active in dental caries.

Improvements in diets reduce the incidence of dysentery and typhoid fever in an institution, according to Abstract No. 89.

Milk and other protective foods are necessary in the diets of pregnant and lactating mothers, as stated in the editorial mentioned in Abstract No. 90.

There is no incompatibility between proteins and starches in the diet, as revealed by the experiments reported in Abstract No. 91.

A new book on Disinfection and Sterilization is reviewed in Abstract No. 92.

Camp Transparent Woman

The Camp Transparent Woman was unveiled recently at the New York Museum of Science and Industry in Rockefeller Center.

The exhibit was brought to America, and is loaned to the museum through the generosity of S. H. Camp, widely known manufacturer of physiological supports of Jackson, Mich., as his contribution to public health education in America.

The figure is constructed entirely of a transparent material making every organ, even the delicately designed veins and circulatory system, clearly visible to the observer as though he were possessed of x-ray eyes. It is now on public exhibition in the Main Hall of The New York Museum of Science and Industry for a brief period prior to a nationwide public health educational tour of 100 cities which is expected to last more than two years. It will be accompanied by a doctor-lecturer who will introduce the exhibit to scientists, the profession and public health officials nationally, and to the general public in a series of lectures to which admission will be free.

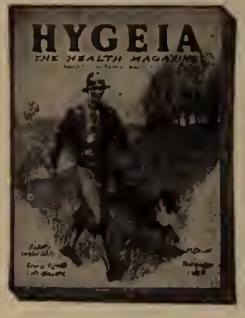
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	23	85%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			11	92%
Brevard	I. F. Bean, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	4	50%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	24	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	10	100%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg., Miami	1st Friday 8:30 P.M.	Rod and Reel Club Hibiscus Island	205	92%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	16	76%
Duval	W. McL. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	146	95%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	38	93%
Hillsborough	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grahle, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	113	95%
Jackson	C. D. Whitaker, M.D., Dekle Bldg. Marianna	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	9	75%
Lake	R. H. Williams, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM..	Eustis	16	100%
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	34	97%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
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THE JOURNAL
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Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XXIII
NO. 4

Jacksonville, Florida, October, 1936

Yearly Subscription, $3.00
Single Copy, 30c

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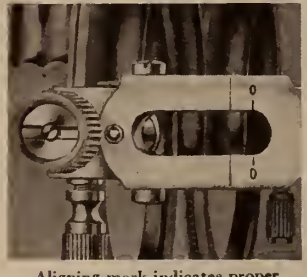
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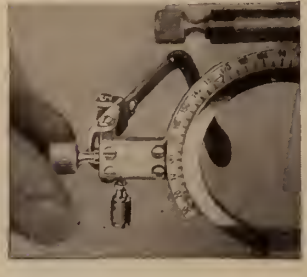
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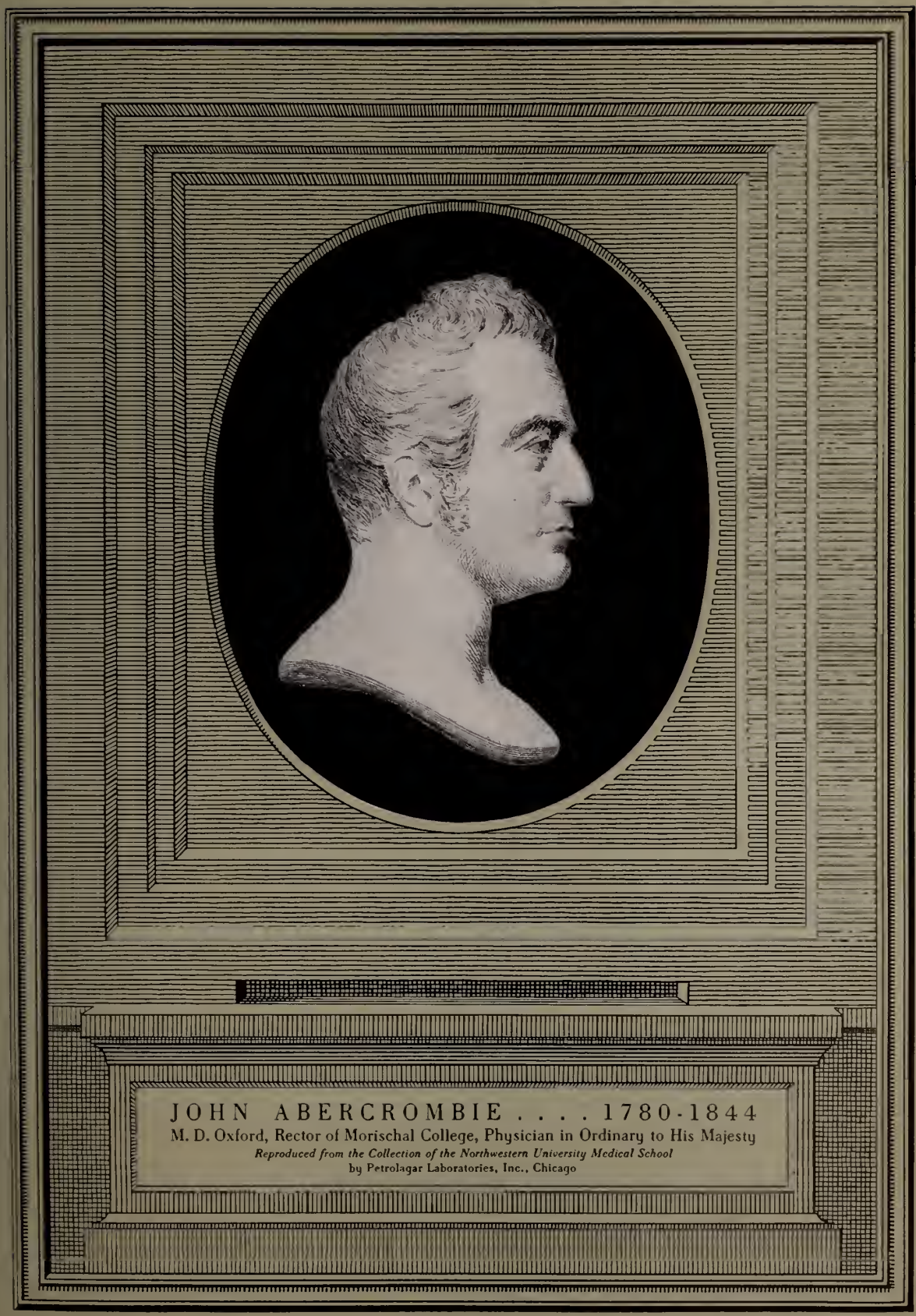
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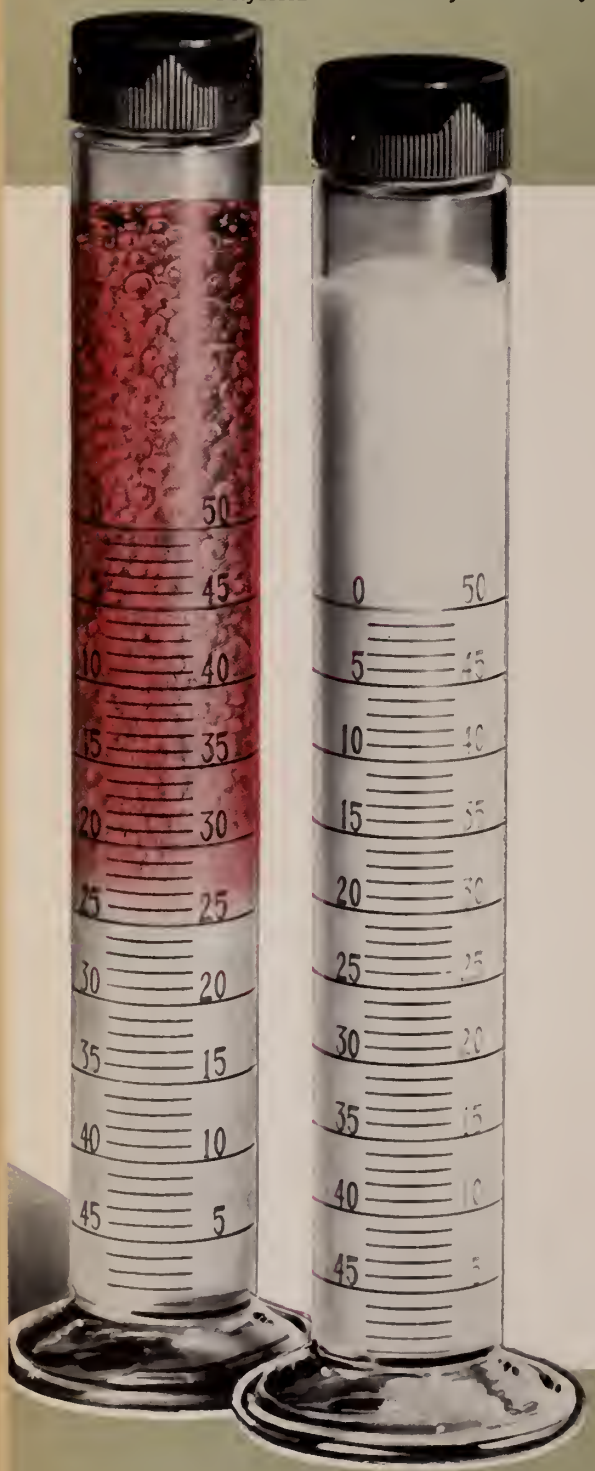
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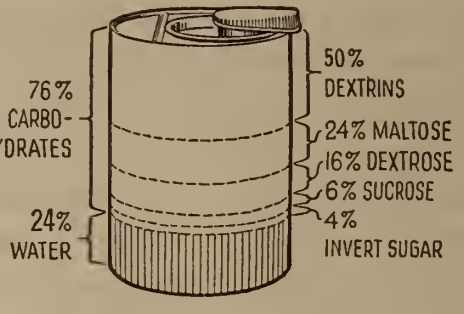


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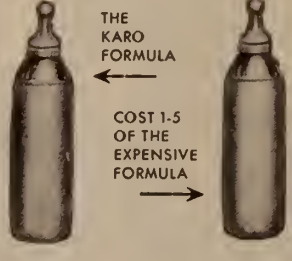


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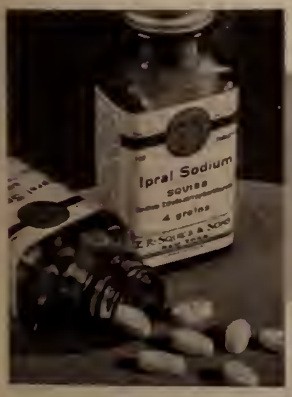
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXIII | Jacksonville, Florida, October, 1936 | Number 4

ACUTE CRANIO-CEREBRAL INJURIES FROM THE NEUROSURGICAL STANDPOINT* †

J. G. Lyerly, M.D.,
Jacksonville.

It is best to present this paper under the title of "Acute Cranio-Cerebral Injuries" since a brain injury is frequently associated with a fracture of the skull. While the brain injury is of primary concern there are times when the fracture itself plays an important part in the diagnosis and treatment.

EMERGENCY TREATMENT

The first thing to consider is the care of the emergency case when first seen a few minutes after the accident. At this time the patient is probably unconscious and in shock from the effects of associated injuries, the loss of blood, and the injury of the central nervous system. It is best not to move him more than is absolutely necessary. He should be put in a quiet place and kept warm with blankets and hot water bottles. Should there be a laceration of the scalp, the bleeding should be controlled by a method producing the least trauma, as finger pressure, hemostats, packing with gauze and pressure bandage, and sometimes by the use of sutures. Stimulation of the cardiac and respiratory centers by hypodermic or intravenous medication may be indicated. This is only done when there are signs of severe shock, or of beginning medullary failure. Likewise intravenous administration of a slightly hypertonic solution of glucose or a hypodermic injection of normal salt solution will be advisable to bring the blood pressure to a nearly normal level. In a severe and prolonged case of shock a blood transfusion will be necessary. A word of caution is necessary against too vigorous stimulation or excessive intravenous injection of fluids because of the danger of increasing an intracranial hemorrhage. Morphine, as a rule, should not be given unless the patient is extremely restless and when no other sedative will quiet the patient. Morphine is a strong respiratory depressant, clouds consciousness, interferes with the reaction of the pupils, and probably aggravates an increased intracranial pressure. The examination should be restricted but sufficiently extensive to determine the patient's general condition. No surgery is indicated during this period except measures to control hemorrhage and to treat shock. After the patient has recovered from shock he may be moved for what other treatment or examination is necessary.

LACERATION OF SCALP

One of the most important things in the management is the proper care of a lacerated scalp. After shaving and the application of antiseptics the edges of the ragged and contused laceration should be excised and sutured under novocaine anesthesia and aseptic precautions. At the same time a fracture or a depressed fracture is ruled out by careful inspection and palpation of the underlying skull.

X-RAY EXAMINATION

It is advisable to have x-ray examinations made of the skull as soon as the patient's condition has improved or when he has recovered from shock. It may clear up a questionable diagnosis of depressed fracture of the skull in the cases of contusion and hematoma of the scalp where palpation through the center of the contused area feels like a depression. The location of the fracture gives information of the location of the injury when there is no overlying scalp injury. In extradural hemorrhage the demonstration of a fracture in the temporal region crossing the groove of the middle meningeal artery is information of great importance. Many fractures at the base of the skull do not show on x-ray examination. They frequently have bleeding from the ears or nose depending on whether the fracture is in the middle or anterior fossa. The leakage of cerebro-spinal

*Read before the Atlantic Coast Line Railway Surgeons Association, Jacksonville, Florida, March 14, 1935.

†This discussion is based on the experience obtained in the management of 2,692 cases of acute brain and skull injuries. Most of these were seen during the twelve years of my association and partnership with Dr. C. C. Coleman, Richmond, Virginia, in neurological surgery. A more detailed report of these cases will be made in a subsequent paper.

fluid from the ears or nose and the demonstration of air in the ventricles or in the subarachnoid space is conclusive proof of fracture of the base of the skull.

EFFECTS OF CONCUSSION

The mildest form of brain injury is concussion. Every patient who has been dazed or rendered unconscious by a head injury has suffered concussion of the brain. Martland[1] showed as a result of concussion there may be hemorrhages in the brain substance. According to his theory a blow on the head produces an inbending of the skull at this point, causing an encroachment on the cranial cavity and a sudden rise of intracranial pressure. At the same time the brain is thrown violently against the opposite side of the skull, producing a contusion or laceration of the brain by contre coup. The sudden increase in pressure causes the cerebrospinal fluid to be forced into the cerebral sulci and perivascular spaces under sufficient pressure to break some of the neuroglia attachments about the blood vessels in the brain substance. This causes a hemorrhage about the injured blood vessel. Autopsy specimens frequently show these pathological changes in the brain associated with edema. At times these deep-seated hemorrhages produce the signs of a severe brain injury associated with unconsciousness over a long period of time. They are frequently located in the basal ganglia and may leave symptoms similar to those of a post-encephalitis.

CONTUSION AND LACERATION

Another class of injuries, usually associated with severe concussion, is contusion and laceration of the brain. These patients are apt to develop an increased intracranial pressure due to hemorrhage and edema of the brain. The development of focal signs such as aphasia, paralysis of one arm, leg, or face, or of the entire side is suggestive of a localized intracranial hemorrhage. If there are signs of compression an exploratory operation through a small opening in the skull in the temporal region on the side of the suspected lesion should be made for diagnosis, and the opening enlarged for a decompression if a hematoma or excessive pressure is found.

LeCount and Apfelbach[2] made some interesting observations on the location of the brain injury in comparison with the fracture of the skull and the site of the blow in a study of 504 cases at autopsy. With the blow in the occipital region the greatest brain injury was by contre coup at the tips of the frontal lobes in 83%. With the fracture in the temporal region the greatest brain damage was on the opposite side in 62%, and with the fracture in the frontal region the most damage was in the occipital area in 25%. This confirms the clinical observation that frequently the greatest brain injury is by contre coup and on the opposite side to the fracture where the blow was received.

TREATMENT

The treatment of the mild concussion case is always one of conservatism, consisting of rest in bed for several days, ice cap to the head and slight elevation of the head. If there is no intracranial hemorrhage or other serious brain injury, complete recovery may be expected in a short time.

The treatment of severe injuries due to contusion and laceration of the brain is directed toward the prevention and relief of increased intracranial pressure. The signs and symptoms of increased pressure are the same as those produced by pressure from other causes, and will be described in connection with extradural hemorrhage. The symptoms of pressure due to edema, however, are not as rapid in onset as in extradural hemorrhage, and the former may take several days or a week to reach the maximum. There may be no rise in systolic blood pressure unless the intracranial pressure becomes extreme, but there is often a rise in the pulse pressure. In order to recognize a rapidly developing increased intracranial pressure it is necessary to make frequent observations of the pulse, respiration, blood pressure and temperature. The nurse is instructed to record the pulse and respiration every thirty minutes and the blood pressure and temperature every hour, as long as the patient's condition justifies it. The purpose of this is to obtain information of an intracranial hemorrhage as early as possible so as to operate before the condition becomes critical.

The patient is put to bed with the head elevated to lessen the venous congestion and pressure in the cranial cavity. To relieve the edema a state of moderate dehydration may be obtained by limiting the fluid intake, by giving hypertonic fluids in the veins, or by increasing the fluid elimination with magnesium sulphate by mouth

or per rectum. On an average from 1000 to 1500 cc. of fluid per 24 hours will be required. A 50% solution of glucose may be given in 50 to 100 cc. doses two or three times daily, in conjunction with the plan of dehydration. The dehydrating effect of the glucose solution is of short duration and of course the effects are only temporary. It is most needed in severe intracranial pressure to relieve the tension before an operation can be performed or to diminish the intradural pressure during the operation. If the patient appears to be doing badly and has a fast pulse and high fever it is best to increase the fluid intake either by vein or under the skin. Too vigorous dehydration will do more harm than good to a seriously ill patient.

A spinal puncture is indicated in the diagnosis and treatment of intracranial pressure associated with brain injuries in a small number of cases. There is danger of it increasing an intracranial hemorrhage when of arterial origin as in extradural hemorrhage. When the hemorrhage is general and diffuse in the subarachnoid space it is of great help to relieve the pressure by removal of the bloody fluid at lumbar puncture. In subarachnoid hemorrhage there is severe headache, stiffness of the neck and the signs of aseptic meningitis which is greatly relieved by spinal drainage. In every case of spinal puncture the pressure should be measured with a manometer to determine the amount of intracranial pressure. A pressure over 200 mm. of water is abnormally high and should be reduced to half by the withdrawal of fluid.

With the use of dehydration and spinal drainage a subtemporal decompression is not often required to relieve a generalized intracranial pressure. There are times, however, when there is high intracranial pressure that a decompression may be necessary, especially when there are focal signs of a localized compression.

EXTRADURAL HEMORRHAGE[3]

Extradural hemorrhage is seen more frequently in the adult and middle-aged and less often in the young and old. In the latter two extremes the dura is more firmly adherent to the skull and the pressure of the bleeding vessels may not be sufficient to separate it from the bone. Short falls and pitched baseballs striking the patient in the temporal region are the most frequent causes. The usual history obtained is that the patient received a blow on the head and was dazed or rendered unconscious for a few minutes. It was followed by a free interval of unconsciousness lasting probably a couple of hours when he again became stuperous or unconscious. This history of the "lucid" or "free" interval nearly always means a traumatic or intracranial hemorrhage. However, there should be other signs before a diagnosis is made.

There will be a severe headache during the period of consciousness as the dura is being stripped from the bone. As the intracranial pressure increases there will be vomiting, slowing of the pulse rate to 50 or 40, stupor and sometimes an elevation of the systolic blood pressure, which however is a less frequent finding than a slowing of the pulse and respiratory rates. Cushing[4] showed in his experiments that when the intracranial pressure exceeds the blood pressure the latter is raised to prevent anemia of the medulla; so probably the reason that the blood pressure is not elevated more in a large number of cases is due to the fact that the intracranial pressure has not reached that of the blood pressure in the arteries of the medullary centers.

Another important sign is a dilated and fixed pupil on the same side as the hemorrhage. It is one of the most important localizing signs and appears fairly early. It is probably due to a partial paralysis of the third nerve, caused by the local compression of the clot. As the clot increases in size the pressure may involve the motor area, resulting in paralysis on the opposite side. If the hemorrhage is on the left side in a right-handed individual there will be aphasia before the loss of consciousness. Before the onset of paralysis there may be convulsive seizures of the Jacksonian type.

The only treatment of extradural hemorrhage is operation for removal of the clot and ligation and control of the bleeding vessels. An incision is made in the temporal region as for a subtemporal decompression, removing an area of bone sufficiently large to adequately remove the clots and explore for the bleeding points. When the bleeding vessel is found it should be ligated or controlled with muscle grafts. A rubber tissue drain should be used for 24 hours. It is best not to pack the wound to control the bleeding if possible, as a more stormy convalescence is expected with its use.

SUBDURAL HEMORRHAGE

A localized subdural hemorrhage may give signs similar to extradural hemorrhage except it is frequently associated with signs of a severe brain injury and prolonged unconsciousness. In chronic subdural hemorrhage there may be a history of a mild head injury as is frequently seen in extradural hemorrhage, and the interval from the time of the injury until the onset of the pressure symptoms may be several weeks or months. The clot becomes encysted by a lining membrane increasing in size from accumulation of fluid until there are pronounced symptoms of increased intracranial pressure developing over a period of time similar to brain tumor. The clot may be found at operation covering most of the surface of a cerebral hemisphere, and in about one-third of the cases it is bilateral. An osteoplastic flap operation is often required to remove the solid clot and cyst wall. Punctures of the cyst through a small opening, with irrigation of the cystic cavity with Ringer's solution and drainage for a few days, is sometimes sufficient when there is no thick clot.

There is a condition called hydroma in which the cerebrospinal fluid escapes through a rupture in the arachnoid membrane and accumulates in the subdural space. The fluid is entrapped and cannot be absorbed in this location, and it produces compression which is not relieved by spinal drainage and dehydration. It can be drained successfully by making an operative opening for a decompression in the temporal region.

DEPRESSED FRACTURE

Depressed fracture of the skull requires an operation to relieve the pressure on the brain. In addition the compound and contaminated one requires early operation to prevent infection. In the case of a simple depressed fracture the danger of infection is not present and a delay of several days may do no harm. A slight depression in the skull in the region of the longitudinal or lateral sinus may be left alone since it may not be pressing on brain tissue, and its removal may cause a severe hemorrhage. An untreated depressed fracture will probably increase brain injury by continuous local compression, although it is felt that the greatest damage was done at the time the fracture was received. To prevent further brain pathology an early removal of the depressed fragments of bone by operation is recommended. It is hoped that by an early operation the chances for the development of serious after effects and epilepsy may be prevented. At operation the fragments of bone should be elevated and sometimes removed to inspect the underlying dura and brain. The brain should be cleansed of clots and loose fragments of tissue by irrigation with normal salt solution, and the dura then carefully closed with fine silk sutures. The fragments of bone are usually replaced in the wound to fill in the cranial defect and prevent deformity. In the contaminated cases it is best to remove the loose pieces of bone and leave the plastic repair of the bone defect to a later date.

THE UNCONSCIOUS PATIENT

The management of the unconscious patient is important, since there is often some swallowing difficulty and the danger of a chest complication. The patient should be turned on the face or on the side so that the secretions can drain from the mouth. In order to facilitate the drainage sometimes it is necessary to elevate the foot of the bed 15 or 20 degrees. Postural drainage is most necessary to relieve an impending pulmonary edema. The use of a suction apparatus in removing the secretions from the pharynx is sometimes very helpful.

The feeding of the unconscious patient is also very important. He will frequently have swallowing difficulty, and will strangle and cough when fluid is put in the mouth. To persist in giving fluids by mouth when there is impairment of deglutition may cause pneumonia and pulmonary edema. It is much safer to give fluids by nasal tube, in the vein, or under the skin as the urgency of the case may be.

LEAKAGE OF CEREBROSPINAL FLUID

The drainage of cerebrospinal fluid and blood from the ears usually means fracture of the base of the skull. It is best not to pack the external auditory canal to stop the drainage because of the danger of reversing the flow of the contaminated material. The management of these cases should consist of cleansing the external ear with alcohol and applying a loose sterile dressing over the ear to absorb the drainage.

The leakage of cerebrospinal fluid from the nose is a serious complication and is associated with fracture of the base of the skull. It means there is a communication between the subarachnoid space or ventricle, and one of the nasal accessory sinuses. It is best not to pack the nose as it would reverse the circulation and hasten the

development of meningitis. The application of antiseptics in the nose is useless since it is impossible to sterilize every part of the nasal mucous membrane. The conservative treatment of this condition is to put the patient in bed with the head slightly elevated. Also by dehydration the formation and drainage of cerebrospinal fluid is checked, giving the opening between the nasal and cranial cavities a better chance to close. It is urgent to instruct the patient to abstain from blowing his nose or sneezing which would tend to force the nasal secretions through the opening into the cranial cavity. Since cerebrospinal rhinorrhea often leads to a purulent meningitis and carries a high mortality there has been a recent trend among neurological surgeons to treat these cases by radical operation during the early stages before meningitis has developed. An osteoplastic flap is turned down in the frontal region and the opening in the dura repaired with a piece of muscle or fascia lata. The presence of air in the ventricles and subarachnoid spaces of the brain on x-ray examination is associated with a cerebrospinal rhinorrhea due to an opening between the cranial and nasal cavities, and it requires the same operative treatment for its cure.

OLD BRAIN INJURIES

It is not the purpose of this paper to discuss the symptomatology and treatment of chronic brain injuries. It is important in this connection to stress the measures which may prevent or lessen the symptoms we usually classify under traumatic neurosis. These symptoms frequently include headache, dizziness, ringing in the ears, nervousness, forgetfulness and fatigability. They may be as severe after a mild head injury as after one of great severity. Encephalographic studies are helpful in clearing up the diagnosis in many of these cases, and incidentally will remove many of the symptoms, allowing the patient to return to work at an early date.

If the patient is kept at rest a due length of time and his intracranial pressure regulated by the measures outlined these symptoms may be reduced to a minimum. At the same time it is important to develop the patient's cooperation and confidence, and allay his fears and anxiety of a permanent cripple due to fracture of the skull. It is up to the surgeon to instill into every patient with a severe or mild head injury the desire to get well.

Cranial defects left from operative procedures such as removal of depressed fragments of bone are frequently a cause of worry for the patient. He is conscious of the hole in the skull and lives in dread of being hit over this region. Early repair of these cranial defects will sometimes relieve the nervous symptoms.

The following conclusions may be drawn:

During the period of shock and state of collapse the patient should be moved as little as possible and the treatment of lacerations of the scalp and extensive examinations should be deferred until there is improvement in the general condition.

Frequent observations should be made of the pulse, respirations, blood pressure, condition of the pupils and state of consciousness to determine compression of the brain such as extradural hemorrhage.

Depressed fractures of the skull should be elevated and the loose fragments of bone replaced in the cranial defect except in the wounds which are contaminated.

Spinal drainage is indicated in the cases of subarachnoid hemorrhage and signs of meningeal irritation.

Occasionally a subtemporal decompression should be done when there are localized findings of compression of the brain.

Dehydration may be used in moderation but it must be borne in mind that a seriously ill patient does not stand dehydration very well and may require free administration of fluids.

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SULPHUR, A FORGOTTEN REMEDY*

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My first recollection of sulphur being used in the treatment of arthritis and neuritis was when I was a boy. It was then a common remedy of old people who suffered from backaches and sore

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the SS. "Florida", April 27, 28 and 29, 1936.

joints to take sulphur and whiskey or sulphur and cream of tartar. I never gave it much thought until I was prescribing medicine in 1893 in South Georgia. I had a patient, a man of about forty-five years, who was suffering from arthritis. I prescribed the usual remedies. As long as he was taking some form of salicylates or iodides, he felt slightly better. I treated him for about a month, after which time I did not see him until two or three months later. I was down town and he drove up, jumped lightly out of his wagon and hitched his horse. I went over and congratulated him and myself on the last remedy which I could see had been successful. He informed me that it was not the last remedy which had given him so much relief, but it was an old prescription which his grandfather and father had taken that had helped him so much. He said, "Doctor, I put a teaspoonful of flower of sulphur into a pint of whiskey and took a good swallow of it at mealtime." From that time I began prescribing sulphur with some success to those who were afflicted with arthritis. However, it did not seem to do all that I had expected, so I became discouraged with its use and resorted to other measures, but those, too, seemed to fail as to the adequate results. After that I forgot all about sulphur in the treatment of arthritis and chronic neuritis.

It was in 1924 when I had a patient whose case was very similar to the one I had in 1893. I gave him the usual treatment of salicylates, iodides and colonic irrigation. As long as he was using these remedies his condition improved. He then left off treatment by the mouth with instructions that he take a colonic flush every night before going to bed. He improved under this treatment, but when he began to get so much better, he left off the colonic flushes and reverted back to the same condition.

In his desperation this patient went to a Northern hospital where they x-rayed him $250.00's worth, and made cultures from the secretion of the nose, tonsils, stomach, and prostate glands and fecal matter. These were all negative. They gave him the salicylates, iodides, and colonic irrigation each night. After a masseur's rub-down, that was practically all that was done for him. He seemed to improve but within six months he was in as bad a condition as he was previously. He went back to the treatment I had prescribed. I did not know of anything that was better than what he had already been through. However, I mentioned to him the old-time remedy of cream of tartar and sulphur taken after each meal, enough to allow one or two soft evacuations a day. He decided to go to Hot Springs, Arkansas. He and his wife left in the car and drove to Tampa the first day. (His trip was made very slowly, because of the discomfort caused from driving.) The second day they made Ocala, where he purchased his first cream of tartar and sulphur tablets, taking one. The next day they drove to White Springs intending to stay a week to try the baths. Two days of bathing in the cold water and he was unable to get out of bed for a week, although he was taking his sulphur and cream of tartar tablets.

After leaving White Springs he was able to drive in one day to Quincy. His condition improved so continually that he drove on to Pensacola, where he remained a week visiting friends. He wrote that he was feeling as well as he did when he left the Northern hospital to come home and that he had been sticking to his cream of tartar and sulphur tablets regularly. From there he drove to New Orleans in one day, stayed a week, and improved a great deal. He then drove to Pine Bluff, Arkansas, in one day. The next day he made Hot Springs. He was feeling so much better that he did not take the baths, but started for the mountains of West Virginia. On that trip he made from 300 to 400 miles a day.

This patient is still under my observation; he is looking younger and better than he did ten years ago. He tells me that his old pain returns if he eats pies, and an excessive amount of beef stews, dumplings, and chicken, or rice and chicken cooked together, or fresh meats cooked in grease. If he leaves off the sulphur for as long as a week he feels that his joints are stiff and that he has neuralgic pains in his shoulders and down his arms. I mention this as a typical case of many that I have treated during the past ten years with sulphur.

My theory is that the conditions we find, such as: stiffness of the joints, and soreness, neuralgia, muscular rheumatism without raise of temperature are produced by a toxin absorbed into the system. We see this in gouty conditions of old men who eat rich foods and an excessive amount of them. It is somewhat similar in a horse which is very hungry, over eats grain and is stiff the next day, commonly called "being foundered." As to whether it is a certain bacteria or flora of the intestines that grows in these

conditions, and produces the toxins, and the lack of sulphur to unite with them, I do not know. But we do know that when sulphur unites with the nitrogenous products of decomposition they become oxidized and are eliminated as indicanuria. I have given sulphur in these conditions when there was no indicanuria. After giving it, there was an abundance of indicanuria and the patient was greatly relieved.

We are all familiar with that form of arthritis which is generally acute and is relieved by removing the foci of infection. A rheumatic inflammation associated with elevated temperature, swelling and pain is generally caused by an infection where the germs are active, having been transported through the circulation into parts of the body from the foci of infection. This is generally known as rheumatic fever and is caused from the streptococcus or other germs in the general circulation. In these cases, it is very distinctive and has nothing to do with arthritis which is relieved through the use of sulphur. The germs in the colon that produce arthritis are fed on certain foods that we eat, and the toxins that they produce have selective affinity for certain tissues such as the joints and a sheath of nerves; thus producing a low grade of inflammatory process. The type of arthritis and neuritis that I wish to stress in the use of sulphur is the type of disease where there is no rise of temperature but a low grade of poisoning which produces pain, soreness, and stiffness, with tenderness on pressure when the toxins are excessive. There is a muscular soreness on exertion which is similar to a man who has been inactive and then takes a great deal of exercise. His muscles are very sore the next day, causing pain at the least motion.

I should like also to bring to your attention a condition that is commonly known by the laity as rheumatism of the joints, caused by the decrepitudes of old age, probably due to the lack of elimination of the toxins or nitrogenous products, which are eliminated in the form of indican. Indole, a product of intestinal bacteria, is capable of producing pathologic changes in the central nervous system when absorbed. Sulphur combined with indole in the intestines, forming indican, thus converts a highly toxic substance into a harmless compound. When sulphur is lacking in the body there is a failure of elimination in the form of indican, for one of the elements of indican is sulphur. Where there is a lack of sulphur in the system, indican cannot be formed, and thus, cannot be eliminated, causing it to accumulate in the system and to be transported into the tissues that have affinity, such as nerve sheaths, sinus and cartilaginous substances such as are around the joints.

I think that sulphur is one of the very vital elements of the human system that has been overlooked. I can only theorize as to why and wherefore the benefits of the use of sulphur in arthritis. It is possible, and very probable, that the forms of arthritis from which I have obtained the most gratifying results with sulphur were those cases in which the flora and intestinal bacteria of the colon were modified in the growth by the presence of sulphur. We know that the gases in the colon of a normal healthy person are mostly composed of sulphur retted hydrogen. It may be the lack of sulphur in the colon which allows the growth of other bacteria which are not normal, and the ptomaines produced are absorbed in the system and produce arthritis of a chronic form. By taking sulphur, the growth of the unfriendly bacteria in the intestines is discouraged, and the growth of the normal bacteria is encouraged. The reason I lay so much importance to the colon is that most of the fluids of nourishment are absorbed there. If the toxin generated by the bacteria is absorbed, it produces the symptom known as arthritis. I think that the same causes that produce arthritis produce a type of neuritis distinctive from that produced by an infective foci, such as an abscessed root of a tooth, sinus or a fistula.

When sulphur is lacking in the system, we have external conditions showing this fact. The hair is brittle and has a tendency to split. The epidermis of the skin is generally harsh and dry with a tendency toward exfoliation. In these conditions I give sulphur in combination with calcium glouconate. It seems that sulphur is not appropriate to remedy these conditions unless there is a form of lime given so that it will be assimilated. Lime and sulphur are natural elements in the nails, skin, and hair. Unless we have these elements in a form that nature can appropriate, we do not get the results that we anticipate. An old and simple test to see if sulphur is being eliminated is to wear silver next to the skin. The sulphur unites with the silver, forming a silver sulphide, which turns the metal dark. This I have found to be a very accurate and simple test.

Sulphur also plays a very important role in the vitality of the cells. I have noticed that when an old hen that has arthritis lays an egg, the yolk of the egg is a pale yellow, and sometimes almost white instead of yellow. These eggs will not hatch. A piece of silver dipped into the yolk will not turn as dark as in the egg with a bright yolk.

In cases of chronic colitis I use a combination of calcium iodide and calcium sulphide. I do not know how it acts, but I have used in colitis of infants, a combination of sulphur ground to a collodial state with a small amount of barbital to allay its irritability at intervals of four hours. Within 24 hours after giving this remedy, the fecal odor of the stool changed to that of a more normal condition.

Some houses are now making colloidal sulphur in liquid form for intramuscular and intravenous use. I have used both of these preparations where sulphur taken by the mouth is probably not converted into a form whereby it gets into the circulation. I have found the colloidal sulphur given intramuscularly to be so painful and the reaction so great that it is impractical to use, although the results have been very satisfactory. The sulphur for intravenous use obtains quicker results and there is no pain.

In conclusion, let me state that sulphur is a natural element of all warm-blooded animals. It is essential to the growth and is a regulator of the oxidation process and metabolism, forming compounds for elimination. It eliminates the amino-acid cystine and is essential in the elimination of indole as the conjugated sulphates. It is slightly a bactericide and fungicide.

I do not want to convey the idea that the results obtained in the use of sulphur have been uniformly good. While I have secured brilliant results in some cases, others have been absolute failures, and so it has been in the use of many other drugs. Let us hope that the day will not be very far away when we can use sulphur and get as perfect results as we have with our other medicines, such as quinine in certain fevers and digitalis in certain heart diseases.

DISCUSSION

Dr. T. M. Rivers, Kissimmee:

I wish to commend this most excellent paper which Doctor Gates has just presented on the subject of sulphur as a forgotten remedy. Many of the remedies of the past, as we now see, are practically inert and are better forgotten. But that is not so with sulphur. Sulphur is coming into use more and more as its uses are becoming known. All of us are aware of the use of sulphur as an insecticide in the treatment of skin diseases. It is also useful in a like manner in the intestinal tract. And it is possible that it might be of some use in the blood stream, but we do not yet know its value there.

Sulphur is useful in medicine more for its oxidizing or chemical effect. Doctor Gates mentioned that sulphur is valuable in oxidizing the indole, converting it into and causing its elimination as indican. In like manner, sulphur is valuable in oxidizing all of the amins, and the amins, as we know, are toxins produced in focal infections. These amins are toxins which produce such diseases as arthritis and neuritis and any agent which aids in destroying their toxic action and bringing about their elimination is of value. This is the real value of sulphur in medicine.

We now have the colloidal sulphur which is more easily administered and more potent. It can be administered either by mouth, intramuscular injection or intravenous injection. Doctor Gates mentioned that it is painful when given by intramuscular injection. This may be eliminated by giving an intravenous injection.

I want to call your attention to the fact that sulphur may produce colloidal shock if not given carefully. Sufficient care must be used in administering sulphur intravenously to avoid this colloidal shock. This may be done by giving it slowly and giving it in minimum doses.

Again I wish to commend Doctor Gates for bringing to us this new field for an old subject.

Dr. Hubbard Gates, Bradenton (concluding):

I had hoped that this would bring out more discussion. I do hate to get up a paper, spend the time on it, unless there is general discussion. Through these discussions we learn something. I learn more from them than from books. I would rather have the experiences of other men and clinical experience. Then we know what we have. No progress would be made in medicine except for our experimentation.

I would like for the members of this Association to go home and study that question, find out

why, when and how to give sulphur and get results. I am trying to find out different uses for it. I study these patients, keep records and go over them every week or two, and I find out sometimes where the faults come in. Sometime in the future I hope to be able to give you the result of my experience with this subject. It is very interesting.

Way back, ten or twelve years ago, I wrote the different manufacturers and asked them if it was possible to get colloidal sulphur. We had obtained good results with colloidal mercury and I wanted to know if I could get a colloidal form of sulphur. They all said there was no way. I asked all the drug men. I wrote every drug manufacturing house in the United States 9, 8, 7, and 5 years ago, and they finally produced colloidal sulphur. I don't know whether I awoke their interest and stimulated them to do this or not.

LIVE LONGER*

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Although the first law of Nature is inherent in every living thing, and the desire for longevity is intuitive, it is sometimes irrational, and some limitations as to its desirability arise in our minds.

When man outlives his usefulness, and has become a burden in his environments, a disease in the body politic, a kind euthanasia would be justified. Personally, should I reach this state, I hope that some courageous colleague will administer to me that blessed Nepenthe which will waft me over to the wise Hindu's *nirvana.* A short life of accomplishment is far more to be desired than a long one of passivity, inertia or uselessness.

What, indeed, is an old age? It is really a stage of life reached by evolution, and may come on soon or late in life; hence, is not to be reckoned always by years. Some men are old at 30, but are not buried until double that age.

A fact brought out in 1928 in a debate of scientists in England showed that the average age of ten men controlling the ten largest companies in England was 76 years, and the directorates of ten of the largest railway companies averaged 70 years.

In 1928 the average age of men in similar positions in the United States averaged only 59 years. However, in the past years, statistics show a decided progress in these ages, and Osler's famous limitation of man's usefulness will not hold good any longer.

In sharp contrast are the ages at which many of our most prominent Americans continued in active life. Edison, Rockefeller, Depew, Dr. Abraham Jacobi, Drs. Oliver Wendell Holmes, Sr. and Jr., Dr. Chas. W. Elliot, Nicholas Murray Butler and hundreds of others have continued in efficient harness 85 and 90 years.

And why not more? The biological observations of Carrel and Loeb for the past thirty years have proved beyond a reasonable doubt that the life of the animal cell is potentially immortal. And the researches of French scientists show that infusoria and monocellula never die; their auto-propagation is by fission and is endless.

From these observations I see no reason why man's life-cycle should be limited to 100 years. Why should a man be laid on the shelf because of years alone if he is efficient?

The greatest of old men loved to be associated with the young and witty, the cheerful, the "live wires." The man who thinks young, acts young, smiles at life and Nature, has it all over the man who is ready for the scrap pile by lolling in an arm chair, soft slippers and kimono, fears the sunlight, shuns the air, is a crank about food, mirth and stimulants. No man is old until he fails to catch the sweet perfume of violets when a pretty woman smiles at him.

The problem is how to prolong the period of efficiency. Of course, heredity plays the greater part. Life and efficiency last longer in women than in men, and longer in married men than in unmarried, for obvious reasons. In women the menopause is supposed to mark the climax. In men there is a corresponding physiological limitation. In women it comes at about 45 years, in men between 50 and 55. By this time most men have become so stereotyped in their habits and lives that it becomes very difficult for them to change. The man may promise but rarely performs.

*Read before the Hillsborough County Medical Society, April 2, 1935.

In Turkey, Bulgaria, Lithunia, Portugal and some other countries in the Orient, men 105 years old are not rare. During the last year a much broadcasted and publicised case was that of a Turk 161 years old, who married his 4th wife at 111, became a widower at 130, and promised to marry again, which he never did. Evidently his endocrine glands were functioning. These old men spend most of their lives in the open, in the country, on farms.

Arteriosclerosis, formerly looked upon as a senile manifestation, is now advanced to one of the common sequences of disease, or heredity, or a disordered life in persons of subnormal resistance, and occurs more frequently now than formerly.

Periodic examinations at least once a year or oftener when cause for doubt exists, have undoubtedly added many years to thousands. The early detection of physical and psychic defects, infections, poisons, hormone or endocrine imbalance, physical and food errors, malignancies, etc., may be checked and treated before it is too late.

Judgment and consistency are always advisable, but it is not good sense to depress the aged with gloomy prognostics, or to deprive them of the real pleasures of middle age. For instance, light wines, beer, coffee, tea and tobacco in moderation are not injurious, especially to those accustomed to use them, but stronger stimulants are inadvisable.

A survey of a large list of octogenarians made by the Metropolitan Life Insurance Co. and the Life Extension Institute showed that only one-fourth smoke, and less than one-fifth are teetotalers.

Sexual indulgence, in persons of both sexes with high blood pressure may prove disastrous. It raises the blood pressure, may induce cerebral hemorrhage or anginal attacks. However, in the normal no special instructions are required.

In the matter of diet, the bulk of meals should consist mainly of raw and cooked vegetables and fruits, especially leafy green vegetables, milk, sour milk, buttermilk and some meat—very little during the summer, and no fresh pork. Excellent salads are made of the tender tops of radishes, turnips, beets, mustard, watercress, nasturtium and similar greens. Roughage and bran are to be used carefully. It is surprising how little food satisfies some of these old people, whilst others are gourmands. The former are the most active and vigorous, and live longer. Some thrive on one meal a day, most, however, taking something very light for breakfast and supper.

Fat producing foods should be restricted, and the body weight kept 5 to 10 pounds below the standard for the age.

The fad of estimating calories and vitamines scientifically is not called for. The moderate eater lives longest and happiest on a balanced diet.

The elimination of toxic elements from the body is the most important function. After 50, when the body becomes more or less static, elimination becomes more important than nourishment.

No part of the human anatomy will compare with the attention and abuses given to the alimentary canal, from feeding to defecation, diet and elimination. The uses of purgatives, cathartics, laxatives, regulators, etc., far exceed the sum total of all other drugs.

The importance of regularity of alvine evacuations is conceded by the most ignorant, but many are really constipated without knowing it. Two evacuations a day instead of one are more nearly the normal. This avenue of elimination seems to be the only one over which man has almost complete control, but there is still lacking the needed instruction in the art of defecation which it merits at the hands of the doctor and hygienist. The fecal urge should not always be depended on, but at the usual daily time persons should go and sit patiently and make the effort.

The best time for bowel evacuation is soon after the morning meal has started peristalsis. However, a good rule, when practicable, is immediately after arising in the morning to sit directly on the bowl of the toilet seat, with the covers raised, and perform the acts of urination and defecation simultaneously. In this position the muscles of the abdomen act normally, more effectively, like that of the dog, which gives an idea of the best position of the body in this act. Strong straining is usually undesirable, but when necessary great help can be obtained by clasping the hands together tightly, also by turning the body to one side, torsioning, thus bringing the oblique muscles into supplementary assistance.

When enemas are called for it is not always necessary to flush the colon with large quantities of water. A 3 or 4 ounce infant rubber bulb syringe answers the purpose, refilling two or three times if needed to start the plug in the

lower rectum, and subsequent contractions.

High colonic irrigation with the regular nozzle of the fountain syringe should be made slowly with the syringe low. Sometimes great comfort and relief is thus obtained but should not be continued long—it may cause overdistention of the colon fibers, and their subsequent weakening. When a purgative is needed some emulsion of mineral oil activated by one of the following: agar, phenolphthalein, cascara, magnesia or psyllium seed is recommended, to be discontinued when advisable.

The most active and vigorous old people are those who practice gymnastic exercises morning and evening. A routine set of movements should be followed, and the time, character, and number of each set of movements and intermissions of rest carefully regulated according to the age, condition of the heart and arteries, blood pressure, fatigue and general state. Persons with myocardial pathology should be especially careful not to use violent, strenuous or prolonged exercises. Not more than 10 or 15 minutes need be devoted to exercise.

Most people neglect to go through the leg exercises, the most beneficial of which is brisk walking, jumping or hopping in a limited way. Walking down stairs with firm steps gives needed tone to the inter-vertebral structures, and spinal ligaments.

Facial wrinkles are neither desirable nor pretty, and can usually be prevented to a certain degree, or greatly improved by regular, systematic, thorough massage, morning and night with the aid of some suitable ointment, preferably cold cream of reliable make, supplemented with lanoline, a small amount of boric acid and soda biborate.

One menongenarian, a fine looking fellow for his age, told me that for years he has massaged his wrinkles 50 times every night without any cosmetics. He is still actively engaged in the same business he began over 60 years ago.

Florida climate attracts thousands of the aged from all parts of the country, all the year around. Here they remain out of doors nearly all day enjoying the calm life, balmy air, sunshine, flowers, birds, etc., of the subtropical clime, and get the lure to return every year or to remain.

A French philosopher said centuries ago, "Men do not die, they kill themselves." Ignorance is the predominant sin. However, in the last analysis men do really live longer today in every sense than during any former world era. Time has been harnessed so that Speed with his cohorts of science, electricity, machinery and alert, progressive minds, has become the reigning Titan, and the accomplishments formerly demanding a century are now speeded through in less than one-fourth that time. Thus man lives longer, happier, more efficiently in these modern, condensed years. Life at best is too short for the ambitious, and its psychology is to work, to evolve, to give service. Elbert Hubbard said, "The Mintage of Wisdom is to know that Rest is Rust, and that real life is in Love, Laughter and Work."

After all we are in pursuit of a single ultimate object—Happiness—which, as once defined by Madame De Stael nearly two centuries ago, was "The pursuit of a laudable object with a reasonable hope of success."

But the end must come to all men—culminated by Death, our loyal Friend of Life, who brings to us our reward, eternal rest, the end of the day, the blessed night.

APHORISMS AND SUMMARY

Sunlight and outdoor life essential.

Frequent deep breathing exercises.

Gymnastics night and morning.

Heart pathology must govern strenuousness.

Stand, sit and walk erect.

Brisk walking daily.

Keep teeth, gums and mouth clean.

Adequate ventilation in sleeping room winter and summer.

Keep warm in all seasons, but don't hug the fire.

Regulate bowels with diet, water and exercise.

Avoid purgatives as much as possible.

Regularity in all habits.

Drink 6 to 8 glasses water every day between meals; very little during the meals.

Keep in harness.

Develop a hobby, requiring action and diversion.

Eat lightly, moderately, regularly.

Keep body weight 5 to 10 pounds below standard for the age.

Don't cut out all fat-forming foods. Reduce them.

Inherited fatness cannot be reduced practically.

An old man should not marry a very young girl.

Seven hours sleep in the 24 is usually sufficient.

A half-hour nap or longer in the afternoon renews energy.

For slight ailment rest in bed, liquid diet, or a few days omission of food.

Don't allow prolonged stay in bed: old people rapidly lose strength and energy.

Senile heart demands slowing down of activities, but not absolute prolonged inertia.

Be temperate in all things except in good cheer, mirth and optimism.

IDIOPATHIC THROMBOCYTOPENIC PURPURA HEMORRHAGICA TREATED BY SPLENECTOMY*

Report of a Case

C. Larimore Perry, M.D.,
and
J. M. McClamroch, M.D.,
Miami.

In April, 1933, G. N., a thirteen-year-old girl, was negative. The girl was given 500 cc. of complaining of a constant and profuse vaginal bleeding of two weeks' duration. Just prior to the beginning of the hemorrhage she had a severe nose bleed, which stopped after the vaginal bleeding began.

She was examined physically and clinically, and it was thought necessary to rule out an early terminating pregnancy. Blood examinations showed a hemoglobin of 27% and a red count of 1,890,000. The white count was 7,000, of which 68% were neutrophiles, 27% lymphocytes, and 5% monocytes. The platelet count at this time was 315,000, the coagulation time 3½ minutes, and the bleeding time 4 minutes. The Kahn test was negative. The girl was given 500 cc. of citrated blood and was allowed to return home with a diagnosis of vicarious menstruation.

On May 19, 1934, the patient was again admitted to the hospital, complaining that she had been bleeding since April 26—rather scantily for the first two weeks but flooding since then to the present time. There was no pain associated with the bleeding. She was running an afternoon temperature as high as 101 degrees. The blood picture at this time showed a red count of 2,100,000, hemoglobin of 35%, and a differential count approximately the same as on the first admission. The platelet count was 90,000, the coagulation time 6¼ minutes, and the bleeding time 32 minutes. She was given a transfusion and sent home ten days after admission.

On June 29 of the same year the patient was again admitted to the hospital with a profuse flooding. She was treated conservatively until July 5, when she was sent home.

On December 27, 1934, the patient was again admitted because of a very severe vaginal hemorrhage. She was also having severe cramp-like pains throughout the lower abdomen; some narcosis was required to control the pain. The blood picture showed the following changes:

Red blood count, 2,600,000; hemoglobin, 48%.

White blood count, 5,600; neutrophiles, 52%; lymphocytes, 30%; eosinophiles, 10%; monocytes, 8%.

Platelet count, 160,000.

Coagulation time, 3¼ minutes.

Bleeding time, 28½ minutes.

Clot retraction time: Clot not retracted at 24 hours.

Fragility: Hemolysis began at 0.42, complete at 0.36.

Blood calcium, 11 mgs.

Icteric index, 4.

Sedimentation time, 250 minutes; index 14 mm.

Aside from the blood changes she showed multiple bruises, especially on the arms and legs. She discolored under the pinch test. The spleen was vaguely palpable. The following manifestations were observed, in summing up the patient's history, physical findings and laboratory data:

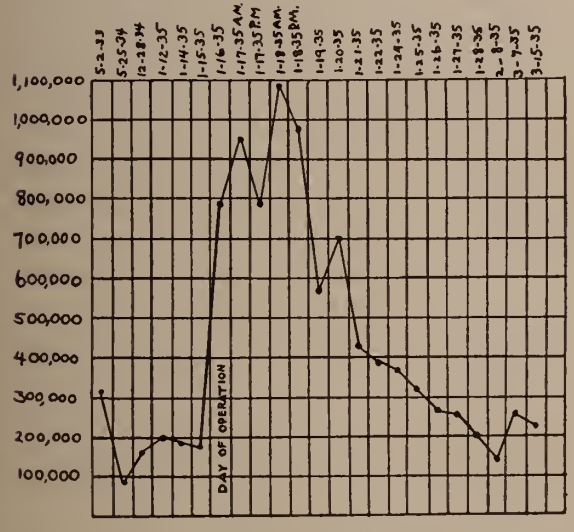
1. Low platelets.
2. Delayed clot retractility.
3. Prolonged bleeding time.
4. Normal coagulation time.
5. Normal regeneration of blood.
6. No morphological changes in the formed elements of the hematopoietic system.
7. Absence of poisoning, as from arsenic, lead, mercury.
8. Absence of foci of infection.
9. History of bruising easily, frequent bleeding from uterus, occasional bleeding from gums.
10. Frequent abdominal pain.
11. Positive Rumpel-Leeds phenomenon.
12. Positive pinch test.

In view of the above mentioned findings there could be little doubt as to the correctness of a diagnosis of idiopathic thrombocytopenic pur-

*Read at staff meeting of Jackson Memorial Hospital, Miami, June, 1935.

pura hemorrhagica. Conservative therapy brought about no improvement. Splenectomy was decided upon and done on January 16, 1935. The patient was given 400 cc. of citrated blood just before going to the operating room.

A long left rectus incision was made and the peritoneum opened. The liver, gall-bladder and stomach were negative. The uterus was infantile. The spleen was delivered into the wound and salt packs were placed behind it. The stomach and intestines were packed off. The lienogastric and lienorenal ligaments were clamped, cut and ligated. The splenic pedicle was doubly ligated with chromic catgut No. 2. The spleen was removed and warm salt packs placed in the fossa. There was no bleeding. The abdomen was closed in layers with chromic catgut No. 2, and four stay sutures of silkworm gut were placed. The skin was closed with dermal. The operation was complete in thirty-five minutes, and the patient was in good condition when taken to her room.



PLATELET COUNT.

The blood picture before and after surgery is interesting:

	1-14-35 Before	1-18-35 After
Red blood count	2,880,000	3,710,000
White blood count	5,600	19,250
Platelet count	190,000	1 090,000
Bleeding time	28 minutes	2½ minutes
Coagulation time	3¼ minutes	3 minutes
Sedimentation time	250 minutes	235 minutes
Blood fragility	0.42%—0.36%	0.42%—0.38%
Clot retraction time	26 hrs. no retract.	One hour

Nine months after the splenectomy the girl is enjoying normal health. She has been recently married, and all symptoms relative to her trouble have subsided.

This case is instructive since the cause of the trouble was not discovered until her fourth hospital admission, when the picture was obvious to those in charge.

RELATIONSHIP OF RADIOLOGY TO PEDIATRICS*

FRAZIER J. PAYTON, M.D.,
Miami Beach.

I have been asked to give a short discussion on the relationship of radiology to pediatrics. Obviously, in its larger sense, it is the same relationship that radiology bears to all of the other branches of medicine with respect to adults, colored by the special problems attending this age group.

The problems involved in this relationship are again divisible: into those problems of the first few months, the middle years, and those approaching adolescence. Indirectly, the relationship also bridges the ante-partum and post-partum periods. With the former we have no concern other than to mention the advances in maternal and fetal measurements, which have a direct bearing on the first few weeks of life, and in many instances, on life for a much greater period. This problem has reached a stage of solution where we may now speak in terms of volume of the fetal head and volume capacity of the various points of constriction in the parturient canal. We are then able to indicate the obvious disproportions which make delivery by normal methods a hazard to the child.

Other than the effects of trauma, one of the most outstanding problems in the first few weeks of life in which radiology plays a part is probably that of the so-called thymic syndrome. As you too well know, the problem is still one of considerable controversy. Radiologists are indecisive in what constitutes an enlarged thymus. There are undoubtedly thymic shadows on the roentgenogram which are considerably larger than average normal, but which are not attended by symptoms suggestive of pressure. Contrarywise, there are also those instances in which there are marked symptoms of pressure, and in which the shadow on the roentgenogram seems hardly sufficient to have produced them. Again,

*Read before the First Annual Meeting of the Florida Pediatric Society held aboard the S.S. "Florida," April 27, 1936.

we are not satisfied with the present explanations of the marked relief of symptoms following relatively small amounts of radiation. The effect can hardly be directly upon the gland. In view of the fact that there is usually an accompanying relative lymphocytosis, is it not entirely within the range of possibility that the effect is purely one of premature aging of white cells which we know are sensitive? This suggests to us that we might well ray elsewhere and secure identical symptomatic relief. This has, in fact, been done. I wonder, therefore, at our enthusiasm for raying the gland directly.

This problem is closely allied with another in this same age period, that of so-called hypertrophic pyloric stenosis. Here again, x-radiation, if the obstruction is not too great, has given marked relief and, in many instances, absolute cure. Radiation over the pylorus is not essential. I and many others have given radiation over the buttocks and lower abdomen and secured relief as readily as in those instances wherein the pyloric region itself was treated.

I am not attempting an exhaustive discussion of all the relations of radiology and pediatrics. I wish merely to raise a few issues; that they may receive your consideration and the cooperation that the problem requires. Obviously, pediatricians and radiologists must look at each other's side of the problem. Neither is sufficient unto itself.

I would mention also the work of Dr. Maurice McPhedran of Philadelphia. He has shown rather conclusively, from a radiographic standpoint, the relationship of non-specific and specific tuberculous infection in the chest. From these findings he has come to the conclusion that non-specific infection in the cardio-diaphragmatic angles offers distinct prognostic improvement when it is present. From the above, he has been able to evolve serological and vaccine therapy for miliary tuberculosis in infants, with marked improvement in prognosis.

To recount a few other instances of interrelationship, radiology is of great importance in the diagnosis and treatment of the splenic anomalies. Its aid in intravenous and retrograde pyelography, especially in the diagnosis of congenital kidney tumor such as Wilm's, is undeniable. Roentgen therapy of such tumors renders them operable.

I should like also to call your attention to the use of gastro-intestinal studies in the first ten years of life. There are certainly insufficient such investigations done. For example, too frequently congenital bands or other abdominal adhesions are discovered which have been producing low grade obstructions for a considerable period.

The investigation by x-ray for foci of infection in and about the sinuses and pharynx is too well known to warrant lengthy discussion. I should like to warn, however, that cloudy sinuses are not necessarily prima facie evidence (at the time they are examined) just as merely enlarged turbinates seen on inspection of the nose do not prove acute pathology. Other clinical signs and symptoms are just as important or more so.

I hesitate somewhat to call your attention to x-ray treatment of the many acute inflammatory conditions. I seem to hear you saying that these x-ray men believe that everything is curable by the use of x-ray. The facts, however, speak for themselves. The literature, especially foreign, is literally filled with authentic reports of the effective and speedy handling of a tremendous number of acute inflammatory conditions, especially in the more superficial tissues. The theory that x-ray action on such conditions is by destruction of accumulated white cells in the neighboring tissues, seems at first paradoxical. It does not seem so, however, when we consider that such action probably speedily liberates into the surrounding tissues, hormones and other by-products which are essential to healing. This action, then, is merely aiding the natural course of events and speeding the outcome.

I could not, of course, consider that I have covered the field of relationship between these two great branches of medicine. I have sought only to bring to your attention again some of the more obvious relationships, in the hope that we will be stimulated to freer discussion and acknowledgement of our interdependence. I cannot close without stressing the fact that diagnostic roentgenology never has been and never will be an excuse for lack of accurate clinical observation.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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SOUTHERN MEDICAL ASSOCIATION MEETING, BALTIMORE, MARYLAND NOVEMBER 17-20, 1936

Each November for the past twenty-nine years the physicians of the South have looked forward with pleasant anticipation to the meeting of the Southern Medical Association. This organization was founded by the leaders of medicine in the Southland. It has grown at such a remarkable rate that today it is the second largest Medical Society in the world.

Each year the meeting is held in a different section of the southern area in some city which is outstanding as a medical centre. This year it is very fortunate that the meeting will be held in the city of Baltimore, Maryland. The headquarters of the Association will be at the Lord Baltimore Hotel.

The programs of the various sections have been assembled with the greatest care to serve the interest of the rank and file of the medical profession. The greatest teachers and practitioners have been chosen as essayists on the programs. One day of the meeting will be given to the Baltimore physicians. Clinics will be held and papers will be given by representatives of both of the great universities, viz., the University of Maryland and the Johns Hopkins Medical School.

No physician can fail to be benefited by attending this meeting. You owe it to your patients and yourselves to go away at least once a year for professional betterment.

Baltimore is one of the most delightful cities in our country and has many more things to interest the doctor, his wife and family than the ordinary city. The citizens of this city were of the first and still are the staunchest advocates of true democracy.

Several members of the Florida medical profession have been honored by this great association. Florida has had the honor of having two Presidents, the late Dr. J. M. Jackson, Miami, and Dr. H. Marshall Taylor of Jacksonville. Dr. R. H. McGinnis of Jacksonville has served as Vice-President. In recent years Doctors J. Lee Kirby-Smith and Luther Holloway have served both as secretary and chairman of the sections of Dermatology and Pediatrics respectively.

The railroads, steamship and air lines are cooperating in rendering excellent service to those who will attend this convention.

November in Baltimore is one of the most delightful seasons of the year.

ON TO BALTIMORE!

GOOD PRACTICE

Within the last decade, medical, as well as social and political adjustments, have occurred at an unusually rapid rate.

It has been said that no specialty has a right to exist as such unless it is contributing something new to medicine. Laboratory investigation paves the way of progress but the work of the research man is, to a large measure, wasted if the results are not applied clinically and, more, translated into terms which the layman can understand. It is essential for the physician to make the daily routine of his practice keep step with this advancement.

Some years ago, Dr. Clifford Sweet said: "When the general practitioner learns to examine ears and do urinalyses, we will have to give up pediatrics and try new outlets for our efforts." He had just opened the ears of a child whose intestinal tract had been polished to a nicety with castor oil and enemas for the previous week. The large element of truth in Dr. Sweet's statement is now evident. In an increasing number of instances the general practitioner, fifty per cent of whose work, it is said, deals with children, has learned not only to examine ears but to treat

FLORIDA MEDICAL SPECIAL

TO

SOUTHERN MEDICAL ASSOCIATION



BALTIMORE, MARYLAND

For the convenience of members attending the 30th Annual Meeting of the Southern Medical Association, November 17-20, Baltimore, Maryland, arrangements have been perfected for a "FLORIDA MEDICAL SPECIAL."

Through sleepers will be operated from Miami, Tampa, St. Petersburg, and Jacksonville.

ROUND-TRIP FARES

STARTING POINT	PRICE
Clearwater	$43.30
Deland	38.35
Daytona Beach	38.40
Fort Myers	45.75
Fort Pierce	43.70
Gainesville	36.80
Jacksonville	34.00
Lakeland	41.60
Miami	48.65
Ocala	38.05
Orlando	39.85
Palatka	36.20
Sonford	39.00
Savannah, Ga.	27.15
St. Petersburg	43.40
Tampa	42.45
Winter Haven	41.75
West Palm Beach	45.95

Proportionate fares from other points

SCHEDULE

STARTING POINT	ROUTE	TIME	DATE
Lv. Miami	F. E. C.	11:00 am	Sunday ... November 15
Lv. West Palm Beach	F. E. C.	12:40 pm	" " 15
Lv. Fort Pierce	F. E. C.	2:08 pm	" " 15
Lv. Daytona Beach	F. E. C.	4:52 pm	" " 15
Lv. St. Augustine	F. E. C.	6:10 pm	" " 15
Lv. Tampa	A. C. L.	1:10 pm	Sunday ... November 15
Lv. Lakeland	A. C. L.	2:05 pm	" " 15
Lv. Orlando	A. C. L.	3:25 pm	" " 15
Lv. Sanford	A. C. L.	4:15 pm	" " 15
Lv. Palatka	A. C. L.	5:35 pm	" " 15
Lv. St. Petersburg	A. C. L.	10:30 am	Sunday ... November 15
Lv. Clearwater	A. C. L.	11:05 am	" " 15
Lv. Ocala	A. C. L.	2:55 pm	" " 15
Lv. Goinesville	A. C. L.	4:18 pm	" " 15
Lv. Jacksonville	A. C. L.	7:30 pm	Sunday ... November 15
Lv. Savannah	A. C. L.	10:35 pm	" " 15
Ar. Richmond	A. C. L.	8:35 am	Monday ... November 16
Ar. Washington	R. F. & P.	11:25 am	" " 16
Ar. Baltimore	P. R. R.	12:50 pm	" " 16

TICKETS ON SALE DAILY; RETURN LIMIT 15 DAYS

PULLMAN RATES: Jacksonville-Baltimore (one way)
Lower Berth, $6.00; Upper Berth, $4.80; Compartment, $17.00; Drawing Room, $21.00
(Proportionate Rates from other points)

Through sleepers from Miami, Tampa and St. Petersburg will be attached to the FLORIDA MEDICAL SPECIAL at Jacksonville.

Members from the western portion of the state will join the train at Jacksonville.

RESERVATIONS: Apply to representative of the Florida East Coast Railway or of the Atlantic Coast Line Railroad.

Members desiring to visit New York may do so at an added cost of $11.20 for the round-trip fare.



FLY to the
SOUTHERN MEDICAL ASSOCIATION SESSION, BALTIMORE, MD., November 17-20, 1936

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AN OUTSTANDING MEDICAL MEETING — the Annual Meeting of the Southern Medical Association in Baltimore in mid November. In the twelve general clinical sessions, the sixteen sections, the six independent medical societies meeting conjointly, and the scientific and technical exhibits, every phase of medicine and surgery will be covered—the last word in modern, practical, scientific medicine and surgery. Addresses and papers by distinguished clinicians not only from the South, but from all over the United States.

Regardless of what any physician may be interested in, regardless of how general or how limited his interest, there will be at Baltimore a program to challenge that interest and make it worth while for him to attend.

EVERY PHYSICIAN IN THE SOUTH who is a member of his state and county medical societies can be and should be a member of the Southern Medical Association. The annual dues of $4.00 include the Association's own Journal each month, the Southern Medical Journal — the equal of any, better than many.

SOUTHERN MEDICAL ASSOCIATION
Empire Building
BIRMINGHAM, ALABAMA

otitis media adequately. This betterment in the care of acute infections in children is not limited to otitis media. It has become an exception, rather than a rule, to discover a missed case of pyuria. It is unusual this day and time, to be called into consultation and find that a thorough check of urine and blood has not been made. "Teething" and a "stomach upset" have ceased to be prevailing diagnoses. Not often do you see a case of dehydration in consultation where it has been possible for the attending physician to impress upon the mother the importance of the fluid intake. Even the castor oil bottle no longer occupies a front seat in the medicine cabinet. The common practice of administering a teaspoonful of castor oil on the second day of life is passe.

When any physician who is not confining his work to a specialty is able to perform the work of any of the many fields of medicine as well as a specialist, there seems no logical reason why he should receive anything but praise. It is a challenge to the specialist to raise the standard of his work and put forth his best efforts to further advance his particular field; in other words, be progressive.

CLINICAL CONFERENCE

The recent Clinical Conference of the Florida Section of the Southeastern Surgical Congress, held at the Orange General Hospital in Orlando August 29th, was a decided success measured by the number in attendance and the quality of subjects presented and discussed. The attendance was better than anticipated. Orlando is ideally situated and convenient for a large section of the profession to attend such meetings. This, with the high quality of the program, brought together the greatest number ever to attend a similar conference in Orlando.

Clinical conferences of different groups are becoming more numerous and are reaching and benefiting a greater number of the profession as they should. Such programs, presented by teachers selected from medical centers, assisted by members from the territory served, carry to the body of the profession the latest advancements in medicine and surgery, encourage further study and the application of the very latest facts for the relief of human suffering.

There is an individuality about the medical profession that carries it on and on in an endless search for facts. The revolutionary changes of society in recent years have made no greater test of any occupation or profession than that facing the medical profession. We can be proud of the successful manner in which this challenge has been met in the further solution of problems of cause or cure of disease and the best service it was able to give, often without a hope of any material reward.

Further proof, if any is needed, of the constant progress of the profession can be found in the manner in which a good working theory on disease and its treatment is discarded to accept and apply proven facts. Especially is this true of older members of the profession.

PHYSICIANS' HEALTH AND ACCIDENT INSURANCE

Because a number of our members had requested information relative to the Postal Indemnity Company of Dallas, Texas, which had circularized the doctors in Florida, a letter was written to the State Insurance Commissioner, relative to the standing of this company. The following reply, which is self-explanatory, has been received:

"September 10, 1936.

"Florida Medical Association,
P. O. Box 1018,
Jacksonville, Florida.

"Gentlemen:

"Replying to your letter of the 9th instant, the Postal Indemnity Company of Dallas, Texas, is not authorized to transact an insurance business in this State. Therefore, we are unable to give you a copy of its financial statement.

"This Department always advises strongly against insurance in unauthorized companies and associations.

"Yours very truly,
W. V. KNOTT,
State Treasurer and
Insurance Commissioner."

STATE NEWS ITEMS

Dr. Joseph H. Lucinian of Miami left September 29 to attend the American Roentgen Ray Society meeting in Cleveland. He will also visit Detroit where he will attend several clinics.

* * *

Mr. and Mrs. Benjamin Hampton Lindsey, Sr., announce the marriage of their daughter, Mary Lee, to Dr. Frank Van Chappell on September 12, 1936, at Perry.

The Orange County Medical Society held its annual picnic and barbecue at the Dubsdread Country Club, Saturday afternoon, August 29, and it was declared by those present to be the most successful they had ever attended. Approximately 160 members of the Florida Medical Association from all sections of the state were present. The barbecue and Brunswick stew were the most delicious to date. Several committee meetings of the Association were held during the day and, in all, the affair was considered a great success. The crowd was augmented by members of the Southeastern Surgical Congress who were attending their meeting at the Orange General Hospital the same day. The Orange County Medical Society will continue to give these picnics annually and invite all members of the Florida Medical Association. The time of the next meeting will be announced early this coming year so that everyone can prepare to take advantage of it.

* * *

Six members of the Association were in attendance at the Medical Reese Tumor Clinic Postgraduate Course held in Chicago, September 21 to 27: Drs. H. O. Brown, Tampa; O. O. Feaster, St. Petersburg; Frederick K. Herpel, W. Palm Beach; A. G. Levin, Miami; H. B. McEuen, Jacksonville, and Gerard Raap, Miami. The total attendance was 140. Principal lecturers were Dr. Henri Coutard, Paris; Sir George Lenthal Cheatle, London, and Dr. Max Cutler of Chicago. Dr. Morris Fishbein of Chicago was the principal speaker at the banquet.

* * *

Dr. L. M. Anderson of Lake City, a member of the Association's Committee on Scientific Work, was a visitor in Jacksonville recently, attending a meeting of the Shrine. He also visited the Florida Medical Association office and a number of officers and members of the Association. Doctor Anderson's frequent visits to the Association headquarters are always welcome.

* * *

Dr. and Mrs. Carl D. Hoffmann of Orlando returned on September 17 from Southampton on the President Roosevelt. Doctor Hoffmann spent five weeks visiting gynecological clinics and hospitals in Dublin, Glasgow, Edinburgh, Manchester and London.

* * *

Dr. J. H. Pierpont of Pensacola has returned from a month's vacation spent in the North Carolina mountains.

Dr. and Mrs. Harold D. Van Schaick of Jacksonville are spending their annual vacation in the North this month. Doctor Van Schaick planned to attend clinics in Philadelphia, New York, Cleveland and Chicago as well as the International Medical Assembly at St. Paul.

* * *

The next written examination and review of case histories of Group B applicants by the American Board of Obstetrics and Gynecology will be held in the various cities in the United States and Canada on Saturday, November 7, 1936, and on Saturday, March 6, 1937. The next general examination for all candidates (Groups A and B) will be held in Atlantic City, N. J., June 8 and 9, 1937. Application blanks may be obtained from Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh, Pennsylvania. Applications for these examinations must be filed in the secretary's office not later than sixty days prior to the scheduled date of examination.

* * *

Dr. M. A. Lischkoff of Pensacola spent his vacation in New York City and remained to attend the meeting of the American Academy of Ophthalmology and Otolaryngology.

* * *

Dr. R. H. McKay has returned from two months of study in Europe, and has opened offices at 303 Ingraham Building, Miami. Doctor McKay was formerly located at Tampa.

* * *

Dr. and Mrs. C. D. Whitaker of Marianna announce the birth of a son, Courtland Daniel Whitaker, Jr., on August 8, at Jacksonville.

* * *

Dr. Ralph Gowdy and family of Miami Beach have returned from a two months' trip to North Carolina and Minnesota. Doctor Gowdy attended surgical clinics in Chicago and at the Mayo Clinic.

* * *

The many friends of Dr. F. W. Krueger of Jacksonville, will regret to learn of the death of his father, Fred Krueger, in Gilead, Nebraska. Mr. Krueger was 78 years old at the time of his death.

* * *

Dr. Hugh West of DeLand has returned from a European trip. He visited clinics in London, Oslo, Stockholm, Upsala and Gothenburg this summer while traveling with the Southern Society of Clinical Surgeons.

Dr. William H. McCullaugh announces the opening of offices for the practice of neurology and psychiatry, at 441 St. James Building, Jacksonville.

* * *

Dr. and Mrs. Aaron Z. Oberdorfer of Jacksonville announce the birth of a son, Paul William, on September 5.

* * *

Dr. Harold D. Van Schaick of Jacksonville was recently appointed a member of the State Board of Medical Examiners by Governor Sholtz. Doctor Van Schaick succeeds Dr. S. E. Driskell of Jacksonville, who held this position for a number of years.

* * *

Dr. R. Sam Mosley announces the opening of offices in the Seybold Building, Miami.

* * *

Dr. and Mrs. Max Ghertler of Miami have returned from Roscoe, N. Y., after a stay of two months.

* * *

Members of the Association will be interested to know that the Surgical Supply Company has opened its fourth store which will be located at 33 E. Pine Street, Orlando. Other branches of this company are located at Jacksonville, Tampa and Miami.

* * *

Dr. Shaler Richardson of Jacksonville recently returned from New York where he attended the meeting of the Academy of Ophthalmology and Otolaryngology.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the September meeting of the Dade County Medical Society, held at the Elks Club, September 4, the principal speaker was Dr. Jack A. McKenzie who presented a paper on "Foreign Body in the Bladder". The discussion to this paper was opened by Drs. Milton Coplan and W. L. Fitzgerald.

Dr. Spencer A. Folsom of Orlando was guest speaker at the October meeting of this Society. He chose for his subject, "Heart Disease" which he illustrated with moving picture films of the heart in action.



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GYNECOLOGY—Three Months Course; Intensive Two Weeks Course starting October 19th.

FRACTURES AND TRAUMATIC SURGERY—Informal Proctical Course; Intensive Ten-Doy Course starting Februory, 1937.

EAR, NOSE AND THROAT—Infarmal Caurse; Personal Courses; Intensive Ten-Day Course starting April, 1937.

OPHTHALMOLOGY—Intensive Two Weeks Course starting April, 1937.

UROLOGY—General Course Two Manths; Intensive Course Two Weeks; Special Courses.

CYSTOSCOPY—Intensive Caurse every twa weeks (attendance limited).

General, Intensive and Special Courses in Obstetrics, Pediatrics, Tuberculasis, Raentgenology, Electrocardiography, Dermatology and Syphilalogy, Pathology, Neurology, Topogrophical and Surgical Anatomy, Physical Therapy, Gastro-Enterology, Allergy, Rectol Diseases, Varicase Veins, and Psychiatry.

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DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Jacaranda Hotel, Avon Park on the evening of September 9. The scientific program consisted of two papers: "The Elliott Treatment, with Report of 33 Cases" by Dr. H. V. Weems, and "Merkel's Treatment with Report of Two Cases" by Dr. W. H. Peacock.

Present at this meeting were Doctors H. P. Bevis, G. F. Highsmith, C. H. Kirkpatrick, G. S. McKnight, G. H. McSwain of Arcadia; L. W. Martin, and H. V. Weems of Sebring; W. H. Peacock and B. D. Spears of Wauchula and I. W. Chandler of Avon Park.

It was decided to hold the October meeting at Sebring.

DUVAL COUNTY MEDICAL SOCIETY

The October meeting of the Duval County Medical Society was held at the Mayflower Hotel on the evening of the 6th. The scientific program consisted of an article by Dr. T. Z. Cason: "Heart Block, with Moving Picture Demonstration of Heart and Electrocardiograph." Reports of committees, miscellaneous business and refreshments followed.

PINELLAS COUNTY MEDICAL SOCIETY

The first bi-monthly meeting of the Pinellas County Medical Society was held September 4 at the Shrine Club. Capt. N. W. Gable, Jr., who was principal speaker discussed "An Army Ambulance Unit." Members of the Army and Navy Club and Reserve Officers' Association were invited to attend this meeting.

The second meeting of the month was held September 18. The scientific program consisted of a paper by Dr. A. S. Anderson on "Oxygen Therapy."

A report of the new officers for the Pinellas County Medical Society has just been received, as follows:

President—N. M. Marr, St. Petersburg.
First Vice-Pres.—Earl C. MacCordy, St. Petersburg.
Second Vice-Pres.—L. W. Horne, St. Petersburg.
Secy-Treas.—W. C. McConnell, St. Petersburg.
Censors—N. W. Gable, Jr., St. Petersburg, and H. E. Winchester, Dunedin.

These officers will serve until October, 1937.

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Mrs. S. M. Copeland, President-elect *Jacksonville*
Mrs. Gordon Ira, Vice-President *Jacksonville*
Mrs. Robert D. Ferguson, Secretary-Treasurer *Ocala*
Mrs. O. O. Feaster, Corresponding Secretary . . *St. Petersburg*
Mrs. E. W. Veal, Historian *South Jacksonville*
Mrs. L. C. Ingram, Parliamentarian *Orlando*

COMMITTEE CHAIRMEN

Mrs. John Wilson, Hygeia *Lakeland*
Mrs. A. L. Walters, Program *Miami*
Mrs. E. M. Hendricks, Public Relations *Ft. Lauderdale*
Mrs. Wilburn Lassiter, Press and Publicity *Gainesville*
Mrs. Walter A. Weed, Finance *Lakeland*

Summer Activities

Members of the Pinellas County Medical Auxiliary were invited to attend three meetings and social affairs of the Pinellas County Medical Society this summer, all of which were most successful, being both enjoyable and well attended.

The first affair was held at the Lakewood Country Club in June and was in the form of a golf-dinner dance. Our new State President, Mrs. W. W. Harden, responded very graciously to a request for an impromptu talk. She then introduced our new State Corresponding Secretary, Mrs. O. O. Feaster, and the newly elected officers of the Pinellas Auxiliary who were present.

The second affair to which the Auxiliary was invited, was in the form of a swimming party and dinner dance held at the Jungle Beach Club in July for the pleasure of the members of the Pinellas Dental Society and their wives. Dr. Grace Whitford of Ozona, who presided in the absence of the President, Dr. F. E. Kauffman, gave a short talk as did also the presidents of the Pinellas Dental Society and the Dental Auxiliary, Dr. and Mrs. J. E. Walker. The program closed with a talk on the "Devotion and Cooperation of Physicians and Dentists in Their Respective Fields" by Mrs. Franklin W. Roush.

The final affair was a dinner dance given at the St. Petersburg Yacht Club in August. The club house was made available to the Medical Society through the kindness of Dr. Earl C. MacCordy who holds a membership there.

These affairs accomplished more in the way of friendliness and understanding among those in the local medical profession than anything heretofore tried, and we owe much to Dr. W. C. McConnell for their success.

Mrs. Franklin W. Roush was invited, as the

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president of the Pinellas County Auxiliary, to attend the annual luncheon meeting of the Pinellas County Council of Girl Scouts on May 23rd. She accepted and appreciated greatly this gesture of the Council to familiarize the Medical Auxiliary with the works, aims and accomplishments of the Girl Scouts.

ADVERTISERS' NOTES

VITAMIN B1 THERAPY IN NEUROLOGIC DISEASES

Both on the experimental side and the clinical side it has been repeatedly shown that vitamin B deficiency leads to severe derangements of the central and peripheral nervous systems, and evidence is rapidly accumulating that such deficiency may be of subclinical grade and cause considerable disability without being recognized. Just what the nature of the bio-chemical changes induced in nervous tissue by vitamin B is, is not clear, although a derangement of glucose metabolism appears to be involved.

"Betalin 1" (Vitamin B1, Lilly) Pulvules have been found effective in the treatment of alcoholic polyneuritis and other forms of deficiency of this vitamin. They provide for an economical administration of vitamin B1 to supplement dietary management and are frequently indicated where it is impossible for the patient to assimilate the necessary quantities of this accessory food substance.

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An ounce of Cocomalt (which is the amount used to make one cup or glass) supplies 5 milligrams of Iron in easily assimilated form. Thus three cups or glasses of Cocomalt a day supply 15 milligrams — *which is the amount of Iron recognized as the normal daily nutritional requirement.*

Here, then, is one form in which even a capricious child or a finicky adult will take Iron willingly — and at the same time receive other important food essentials. Prepared as directed, Cocomalt adds 70% more food-energy value to a glass of milk.

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Cocomalt is fortified with Vitamin D under license granted by the Wisconsin Alumni Research Foundation. Each ounce of Cocomalt contains not less than 81 U.S.P. Vitamin D units.

Cocomalt also has a rich Calcium and Phosphorous content. Each cup or glass of Cocomalt in milk provides .32 gram of Calcium and .28 gram of Phosphorus. Thus Cocomalt supplies in good biological ratio three food essentials required for proper growth and development of bones and teeth: Calcium, Phosphorus and Vitamin D.

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For Children's Colds

THE ease of application which makes Benzedrine Inhaler so useful with adults is even more important in treating the congestion occurring in children's head colds. The vapor form—in addition to its greater effectiveness — overcomes the strenuous objections which children show to liquid inhalants as applied by drops, tampons or sprays.

Furthermore, the simplicity of Benzedrine Inhaler makes it especially suitable for pediatric use; it has been shown to have no deleterious effect even on the delicate cilia of the nose. Nor is there any oil to be aspirated and become a potential source of later trouble by accumulating in the lungs (Graef: Am. J. of Path., Vol. xi. No. 5, Sept., 1935).

Secondary reactions are "so infrequent and so mild as to be virtually negligible" (Scarano: Med. Record; Dec. 5, 1934), and even in very young children, overstimulation or other undesirable reactions do not occur with the proper dosage.



FIG. 1. J.M.C. White, female, age 4. June 5, 1936. Acute rhinitis.
11:40 A.M. Two inhalations of Benzedrine inhaler.



FIG. 2. 11:50 A.M. Maximum shrinkage evident.

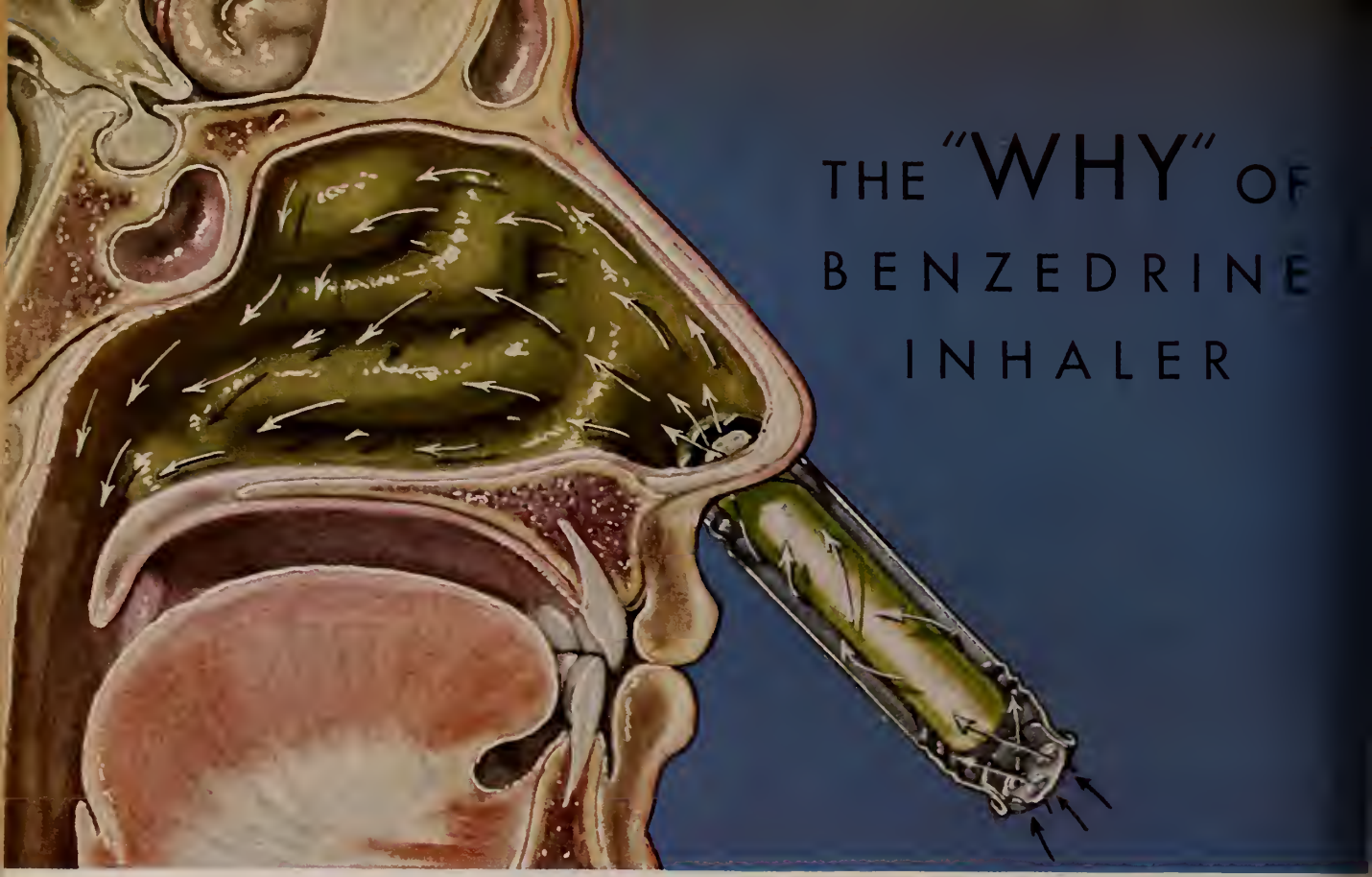
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SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

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- The structure of the rhinological tract is so complicated that, when congestion is present, the whole of the affected area cannot easily be reached by a liquid vasoconstrictor.
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- Thus, though the word "inhaler" may suggest the outmoded aromatic inhalers of the past, actually this presentation of Benzedrine is logically dictated by the properties of the drug itself.
- And Benzedrine Inhaler—effective, convenient and inexpensive—marks a distinct therapeutic advance in the symptomatic treatment of head colds, sinusitis, vasomotor rhinitis, hay fever and nasal congestion generally.

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Each tube is packed with benzyl methyl carbinamine, .325 gm.; oil of lavender, .097 gm.; menthol, .032 gm.

*Trade Mark Reg. U. S. & Can. Pat. Offs.

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Accepted Council on Physical Therapy of the American Medical Association

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Voluntarily, we market only Council-Accepted products because we have faith in the principles for which the Council on Pharmacy and Chemistry (and the Council on Foods) stand.

We have witnessed the three decades during which the Council has brought order out of chaos in the pharmaceutical field. For over thirty years it has stood—alone and unafraid—between the medical profession and unprincipled makers of proprietary preparations.

The Council verifies the composition and analysis of products, and substantiates the claims of manufacturers. By standardizing nomenclature and disapproving therapeutically suggestive trade names, it discourages shotgun therapy and self-medication. It is the only body representing the medical profession that checks inaccurate and unwarranted claims on circulars and advertising as well as on packages and labels.

The Council cooperates, through the N. N. R. and in other ways, with the U. S. Pharmacopoeia Board, testing and evaluating scores of new products which appear during the 10-year interim between Pharmacopoeial revisions.

We are conscious of the fact that the Council has at times been criticized both in and out of the medical profession. We hold no brief for perfection in any human agency. But we subscribe to the fact that the work of the Council is sound in principle; and in this high-pressure day and age, we shudder to think of a return to the proprietary-medicine-quack-nostrum conditions of over thirty years ago, when there was Babel instead of Council.



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★ *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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★ Reprint of papers from N. Y. State Jour. Med. 1935, 35—No. 11, 590; Laryngoscope 1935 XLV, 149-154. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245. ☐

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VITAMINS IN CANNED FOODS

IV. VITAMIN B_1

• The story of vitamin B_1 is quite long and involved. Properly, it has been fully covered at some length in authoritative dissertations on the vitamins (1).

The original vitamin B of Eijkman and of Funk, while definitely possessed of antineuritic potency, is now known to be of a complex nature. Between 1919 and 1926, the vitamin B complex was resolved into vitamins B (B_1) and G (B_2). Subsequent work has indicated the existence of other vitamins in the complex, whose chemical natures or relations to human nutrition are not as yet clearly understood.

As a direct result of many researches on vitamin concentrates, the chemical identity of the crystalline antineuritic factor has recently been described as a derivative of 6-aminopyrimidine (2).

It has been known for many years that vitamin B_1 may be destroyed by heat. In the canning procedure, a number of heat treatments of food may be involved, especially in the thermal "processing" of the product to insure its preservation. In the "process", many foods are subjected to a heat treatment after sealing in the can, to destroy spoilage organisms which may be present on the raw material. In other cases, the food is filled into the cans at a sufficiently high temperature to obtain the same result. Therefore, the question of the effect of the canning procedures on vitamin B_1 frequently arises.

The times and temperatures necessary for the processing of canned foods are governed by a number of factors, important among them being the pH of the food itself. Highly acid foods require only short heat processes at the temperature of hot or boiling water to destroy spoilage organisms. The so-called "non-acid" or "semi-acid" products require higher temperatures — usually 240° F. (116° C.).

As might be expected, acid foods have been found to suffer only a slight loss of vitamin B during canning (3).

The degree of retention of vitamin B_1 in the non-acid foods is not as high as in the acid foods. (4).

This is partly due to the heat treatments accorded them and possibly also to their low acidity, since the vitamin is more stable in acid media.

The facts in the case may be summarized briefly by the statement that commercially canned foods may be depended upon to supply vitamin B to extents consistent with the amounts of the vitamin originally present in the raw materials from which they were prepared. Because of their widespread use, canned foods contribute a notable amount of vitamin B_1 to the American dietary.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) Vitamins: A Survey of Present Knowledge Medical Research Council, Special Report Series, No. 167, 1932. His Majesty's Stationery Office, London

The Vitamins
H. C. Sherman and S. L. Smith
1931 Am. Chem. Soc. Monograph, 2nd Edition

(2) 1935. J. Amer. Chem. Soc. 57, 1751
(3) 1932. Ind. Eng. Chem. 24, 457
(4) 1932. J. Nutrition 5, 307

This is the seventeenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

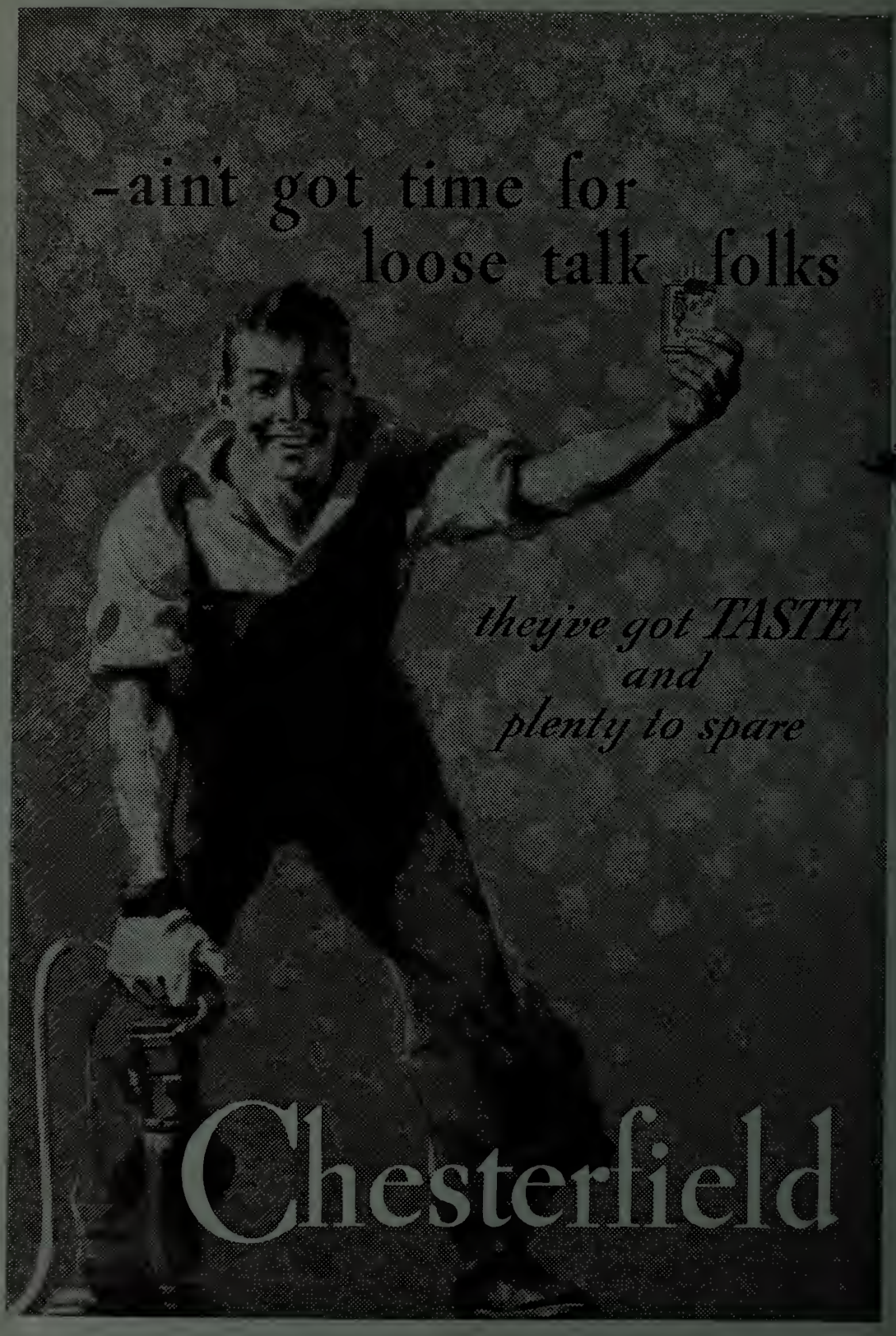
ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	23	85%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			11	92%
Brevard	I. F. Bean, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	4	50%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	24	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	10	100%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg.. Miami	1st Friday 8:30 P.M.	Rod and Reel Club Hibiscus Island	209	99%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	16	76%
Duval	W. McL. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	146	97%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Cbase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	38	93%
Hillsborough	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	114	96%
Jackson	C. D. Whitaker, M.D., Dekle Bldg. Marianna	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	11	73%
Lake	R. H. Williams, M.D., Eustis	W. L. Asbton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis	16	100%
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telepbone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	34	97%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
Manatee	S. G. Hollingsworth, M. D. 451 12tb. St, Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	11	100%
Marion	J. N. Moore, M.D., 210-12 Professional Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	22	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	4	100%
Orange	William E. Sinclair, M. D. Clinic Bldg Orlando	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies	56	100%
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	52	93%
Pasco-Hernando-Citrus	R. D. Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M	Varies	11	85%
Pinellas	N. M. Marr, M.D 812 Power & Light Bldg., St. Petersburg	W. C. McConnell,, M. D. 1005 Equitable Bldg. St. Petersburg	1st. and 3rd. Friday 6:30 P.M.	Sbrine Club St. Petersburg	81	100%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb. April, June, Aug.. Oct., Dec. 1:00 P.M.	Lakeland	54	92%
Putnam	Allen P. Gurganious, M. D. Palatka	A. E. Drexel, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Johns	Herbert E. White, M.D., 401 First Natl. Bank Bldg St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	9	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies	9	82%
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	17	100%
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	12	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies	4	100%
Taylor	J. C. Ellis, M.D., Perry	J. L. Weeks, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	5	83%
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Cbowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies	37	95%
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies	6	100%

NOTE—Secretaries:—Please submit information to complete the above schedule.



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VOLUME XXIII
NO. 5

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70 ways to get more calories

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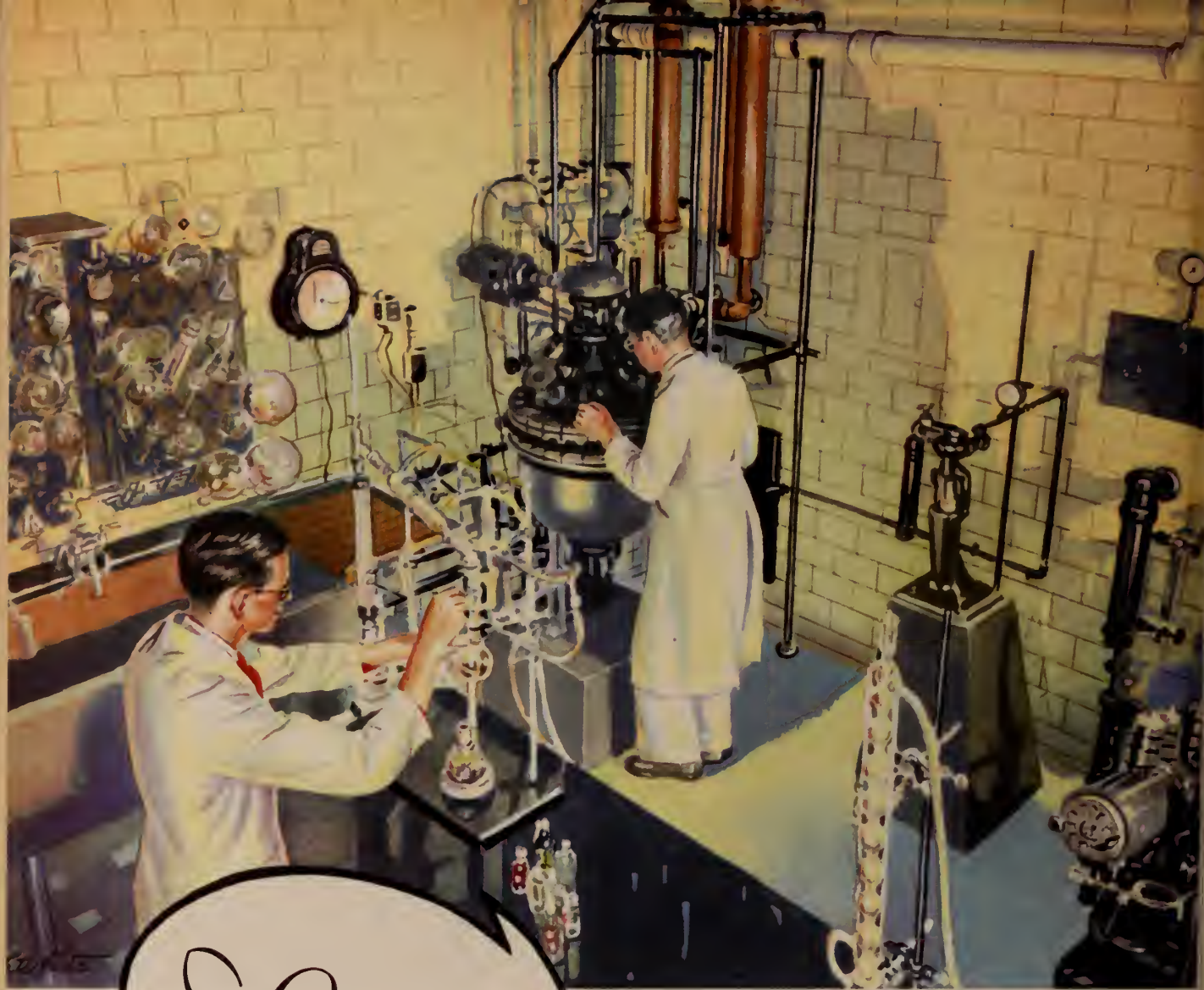
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V. VITAMIN G

● By 1926, it was apparent that the antineuritic vitamin B of earlier investigators was in reality a combination of several vitamins. In that year, Goldberger postulated the existence of a second vitamin associated with the so-called vitamin B "complex" which he designated as the P-P or pellagra-preventive factor. Evidence has been offered that this factor—subsequently named vitamin G—exerts a specific action in the cure and prevention of human pellagra and a similar condition in experimental animals (1).

Since Goldberger's pronouncement, considerable research has been devoted to resolution of the vitamin B complex and, what is equally important, to testing the specificity of vitamin G in the cure of human pellagra (2).

The findings in the laboratory and clinic have not, in some respects, been entirely in accord (3).

As reports of further investigations appeared in the literature, it became clear that the vitamin B complex had been aptly named. At one time claims were made for the existence of as many as eight factors in this complex (4).

While later work has reduced this number, we know today that what has been considered in the past as vitamin G is, in reality, a combination of several factors. A relation between experimental cataract and vitamin G has been described and, recently, another associated factor was postulated (5).

The significance of these individual factors in human nutrition has not as yet been established. However, regardless of this fact, students of nutrition are agreed that we must provide for the inclusion of so-called vitamin G—admittedly a complex—in the daily dietary. It is also obvious that until more is known about the individual components of the complex, we must continue to depend upon present day bioassay methods to determine the "vitamin G" potencies of foods.

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This is the eighteenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXIII | Jacksonville, Florida, November, 1936 | Number 5

SOME FACTS CONCERNING COMMUNICABLE DISEASE*

HENRY HANSON, M.D.,
Jacksonville.†

The experience which the State Board of Health had during the height of the epidemic of poliomyelitis (infantile paralysis) in North Carolina and Virginia last summer, was proof of the fact that the general public needed, and would like to be, better informed about communicable diseases, and how they are transmitted. It became apparent that there exists a great deal of misinformation as to preventive methods.

Alarm was first occasioned by the reported incidence of poliomyelitis in North Carolina. Inquiries came from all classes of the people, asking if it were safe to go to the mountains, and what part of North Carolina was free from the disease. Some thought it dangerous to drive through a town where cases of the disease existed. It seemed at times as though we had gone back to the age of superstition and witchcraft, when it was thought that contagion floated about in the atmosphere.

You may remember the time when the transmission of yellow fever was thought to be through the night air. There are still people who think that malaria is carried in the air, and it was only a few years ago that I heard a man who claimed to be a doctor say that the people in his community contracted malaria by drinking bad water. Yellow fever and malaria, and to this we can now add dengue, *are* diseases transmitted through the air,—but you *must* add the mosquito (Anopheles, or Aedes aegypti) to that air, or there will be no transmission. There is one disease which comes near to being an airborne disease. If one is face to face, and talking with a person sick with pneumonic plague, there is almost invariably enough spray thrown out by the patient to infect those about him. Doctors and nurses who take care of such patients almost inevitably contract the disease if they do not wear a mask over the mouth and nose. It often happens that doctors and nurses are victims before the true nature of the disease is recognized.

Pneumonic plague, however, unlike yellow fever, dengue and malaria, is a bacterial disease. Our knowledge of bacterial diseases originated with Anton van Leeuwenhoek, a Dutch lens grinder of Delft, who saw protozoa in 1675 and bacteria in 1683. It is said that he had 247 microscopes and 419 lenses. He was a man of remarkable industry, and sent over three hundred[1] scientific papers to the Royal Society in London, and many to the French Academy of Sciences. However, it was not until two hundred years later that any importance was attached to the animalculae or "little people" as he called them, which he had seen through his microscope. In 1859 the great Pasteur found that fermentation was due to bacteria. This was the next great step in the proof of the relation of bacteria to disease. From that time on there was a succession of investigations and discoveries, by such men as Koch, Ebert, Loeffler, Neisser, among the Germans; Roux, Simond, Vulpian and others among the French; Lister, Jenner, Harvey and other contemporaries of Pasteur among the English. But we cannot pause for more than a glimpse into this interesting period in the development of scientific knowledge which has enabled the medical profession to protect mankind from suffering and unnecessary sickness. It is inspiring to observe how one physician after the other took note of the new discoveries, and with meager equipment began researches which slowly led to knowledge which has saved thousands, yes millions, of lives.

The refinements of today's medical knowledge offer guarantees that those people who observe proper hygiene, and take advantage of immunizing agents may travel this world with impunity. Contrast this with the frightful mortality which befell the early American settlers while aboard ship and after arrival. Consider what occurred as late as thirty years ago in this country during the 1905 epidemic of yellow fever at New Orleans and Pensacola. Ten years earlier nothing definite was known about the epidemiology of yellow fever. In contrast to that earlier time,

*Read before the Florida East Coast Medical Association, St. Augustine, Nov. 1, 2, 1935.

†Present address: Guayaquil, Ecuador.

the writer, when in charge of the biggest campaign for the control of yellow fever ever inaugurated on the west coast of South America, that of 1919 to 1921, was able, at the end of the year 1921 to notify all legations at Lima, Peru, that we had for the first time in history wiped yellow fever from that coast.

We must make one more reference to the epidemiology of yellow fever to aid in illustrating why some restrictive measures are applied in the control of one disease, and disregarded in others. In yellow fever there is a period of incubation of from 3 to 6 days; in dengue, 4 to 8 days. For that reason, a person coming from a known epidemic or endemic area must be kept in isolation until 6 or 8 days have elapsed since he left the infected area. We are dealing with definite knowledge in such diseases. In other diseases where knowledge is definite, restrictions are applied according to the nature of the disease, its period of incubation and mode of transmission.

I can fully appreciate the nervousness felt by parents at the thought of the possibility of their child contracting infantile paralysis, and would gladly recommend isolation restrictions if there existed accurate knowledge showing a definite period of communicability, or information that a carrier state exists. At present we have neither. The talk about carriers of the virus of poliomyelitis has been on the basis of incomplete information. There are many puzzling, unsolved phases of this disease.

"Poliomyelitis (infantile paralysis) is not a new disease. Historical record shows that it was described by Underwood, an English physician, in 1774. A systematic study of a group of cases which finally established the disease as a clinical entity was published by Jacob von Heine in 1840, in Germany. The disease was first transmitted to monkeys in 1909 by Landstiner and Popper in Vienna. It was shown in 1907 that the disease was transmitted from person to person. It would therefore seem that one of the first precautions in safeguarding one's self against the disease, is to keep out of the room where there are persons sick with it.

"In the North Carolina epidemic, an analysis indicates that about 25% of the cases were urban, and 75% rural. The age incidence which was analyzed by Dr. Morgan of our Staff, shows 85% of the cases to be under 10 years of age. I think it is pretty definite that it is the age period from about one year up to the 10th year that the greatest susceptibility to the disease occurs."[2]

What can be done to control it is, of course, a vital issue and the reason for this discussion. Insofar as protective inoculations are concerned, they are still in the experimental stage. Men who have worked with the convalescent immune serum are of the opinion that those who do not get the serum do as well as those who are inoculated with it. Insafor as the vaccines are concerned, the active brain and nerve cord monkey vaccine is regarded with some risk. It was declared unsafe at the 1935 Conference of the American Public Health Association.

"Our difficulty as a State Health Department[2] has not been on account of the general uneasiness over poliomyelitis, but because of the belief of small groups of individuals that communicable diseases should be controlled by quarantining for a period of two weeks all persons who leave the state, or who have been out of the state for a summer vacation. What the logic of such action is, I do not know. If this is applied to the schools only, it is naturally futile. If you apply it in such a manner as to make it effective you will have to isolate all people who return to the state, in their homes for two weeks. The question then comes up, for what specific cause were these people isolated? Who is to determine when it is safe to release them? If it is for certain carrier conditions, the person who is quarantined has the right to have the fact established that he is a carrier. The person who assumes the right to isolate has the burden of proof to show that the isolated individual is a menace to the health of the community. How many of the transmissible diseases are you to include in the list of possibilities of affecting the health of the community on the part of the people who have been out of the state and wish to come in again? Why not quarantine all tourists who propose coming to Florida because of some indefinite danger that they might bring communicable disease into the state?"

In conclusion I wish to say that the State and City Boards of Health require isolation of carriers and persons sick with communicable disease when there is proof or a reasonable belief that they are sick or carriers, or when the return is from a place where such persons may have been infected and the period of incubation has not yet passed. There is no logical reason to exclude healthy children simply because they

have been out of the state. If there is reason to believe a person is a menace to the community health, such person should be examined by a physician, and the physician's report should be the guide in that case. No person other than the physician or the medical health officer is qualified to advise regarding medical health problems. There is no reason or wisdom in public health regulations issuing from school boards. Children are under better supervision in school than out, and less dangerous as spreaders of contagious diseases.

And finally, in the presence of any instance or epidemic of a communicable disease, let a qualified physician be your source of information and your guide.

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MANAGEMENT OF EARLY AND ADVANCED OBSTRUCTION TO THE URINARY STREAM FROM PROSTATIC ENLARGEMENT*

D. Paul Bird, M.D.,
Lakeland.

Obstruction to the normal flow of urine may be due to a number of different causes, such as stone, tumor, stricture, congenital deformity and syphilis; but in the adult elderly male the largest number of obstructions are caused by abnormal growth of the prostate. This growth may so narrow, constrict and deform the bladder neck as to cause a definite decrease in the size and force of the urinary stream. There have been many classifications presented to describe the different anatomical changes which occur in the shape of the prostate gland. Since many of these classifications have been compiled from data on the appearance of the gland at autopsy, they do not clearly describe the situation in the early physiological cases of obstruction. The prostate gland may enlarge in any number of different directions, but not all of the enlarged tissue will interfere with the stream of urine. It is only that part of the small or large gland which projects into the bladder neck or prostatic urethra and narrows the orifice that causes concern in urinary obstruction. If the gland is large and the opening has not become narrow and constricted, then the individual may still be able to produce a fairly competent stream of urine. If it is clearly understood that in obstruction we are dealing with obstructing tissue, and not merely enlargement, then the average individual with obstruction of an early type will stand less chance of entering the advanced stage of obstruction and possible retention.

Contrary to a popular belief, the degree of obstruction at the bladder neck is not in proportion to the size of the prostate gland. The degree of obstruction is dependent upon the size of the opening left for the escape of urine from the bladder. Because of this, a small gland with a large median lobe can cause as much obstructive interference to urination as a large gland with a relatively small median lobe. The same may be said of both lateral lobes which might occur to cause obstruction. When a lobe has reached sufficient size to cause some decrease in the size or force of the stream, it should be considered as an early obstructive lesion of the prostate gland and bladder neck. If this obstructive lesion remains untreated until it has enlarged or grown so much that urination becomes difficult and extra effort is required to empty the bladder, then the obstruction is advanced and probably accompanied by diminished renal function and retention. Obstruction may be early or advanced in either large or small glands, so rectal palpation will reveal the size or dimensions of the gland but not the degree of urinary obstruction.

Early obstruction to urination is first indicated by some change in the size and force of the stream. The projection distance becomes shortened, and the individual cannot urinate as far or as forcefully as in his younger days. Unless the individual is more observant than the average, such a gradual development will pass unnoticed. And unless questioned about this one feature of urination, it will gradually develop into an advanced state before any thought is given to the accustomed act of urination. He will become used to a small stream and hesitancy in voiding and therefore neglect his condition until forced to seek help because of general discomfort from pain or retention. Even complete retention is not enough to alarm some patients who seem to have unfaltering faith in their urinary system.

Advanced obstruction generally begins when the symptoms from minor obstructions become more severe and acute enough to awaken the individual to the realization that something is going wrong with his ability to urinate. Most cases that come up for treatment belong to this class, and include many with varying amounts of resi-

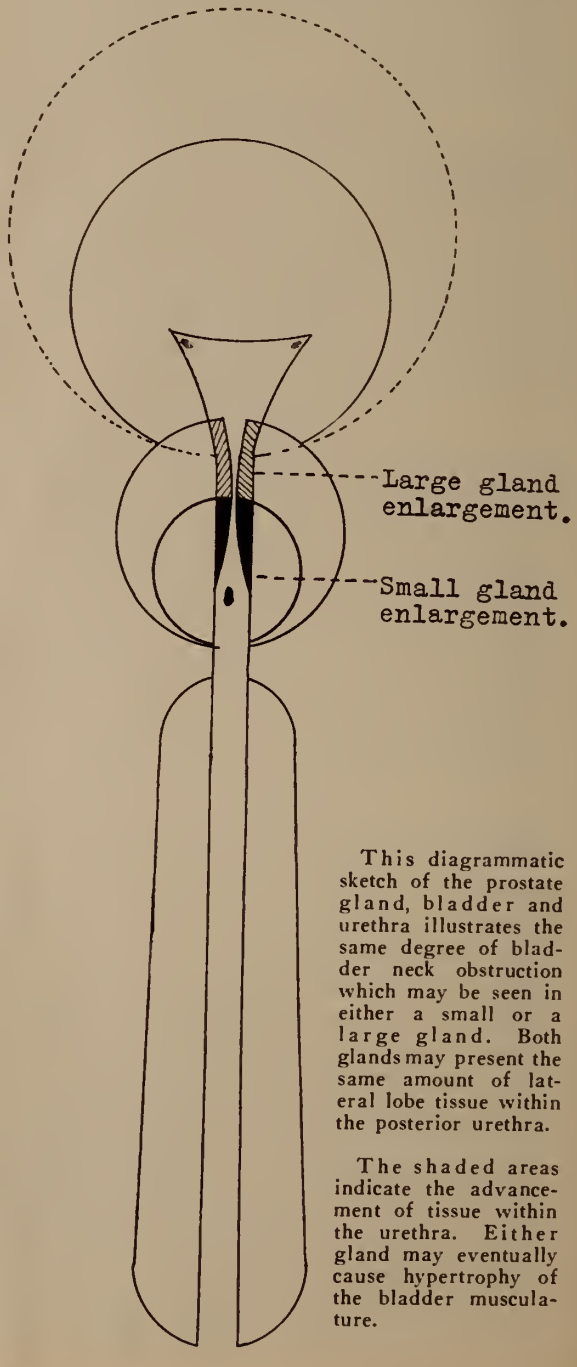
*Read before the DeSoto-Hardee-Highlands County Medical Society, Wauchula, February, 1935.

dual urine. Incontinence both by day and by night is frequently an uncomfortable feature of these cases. Dribbling before and after the act of urination usually goes hand in hand with incontinence. Oftentimes a very definite effort has to be made before the patient can accomplish the act of urination. He will strain and try to force the stream only to find that it flows better when he ceases to strain and relaxes the effort. This may be followed by several such attempts before the patient is satisfied with the empty feeling within his bladder.

If obstruction is complicated by infection, the patient may suffer from a variety of symptoms due to the absorption of the toxins into the bloodstream. Among the most common of these are chronic indigestion and loss of appetite. However, digestive symptoms are not generally as severe or as emaciating as one sees in the more malignant type of disease. Chill, fever, and general malaise indicate infection within the bladder, prostate, or renal pelvis. Even emotional stability is not as frequently disturbed as one would expect in the conditions met within such constant inconvenience. On the whole most of the sufferers are unusually tolerant.

Physical examination with special attention to the heart is an important step in treatment of every case. No one patient can expect to improve or respond unless his heart is strong enough and has reserve enough to withstand some additional burden such as might be required by operation. With the blood pressure reading and heart record in the beginning the physician can complete his examination with his prognosis gradually developing as he finishes his examination of the urinary tract. The patient will first be asked to void and the stream observed as it is passed into the glass, and at the same time one makes note of the effort made in starting, the force while urinating, and the dribbling after effort. The urine is examined for its usual constituents. After voiding, a catheter is passed to determine the amount of residual urine. The passing of the catheter will yield some information in regard to the size and shape of the urethral passage. If cystoscopy can be done without trauma and danger of increasing infection, then such a procedure will give more information than any other single means of examination of the bladder neck. It is the actual vision of the bladder neck, the prostate and its lobes, the posterior urethra and the trigone which gives direct evidence and determines the course to pursue.

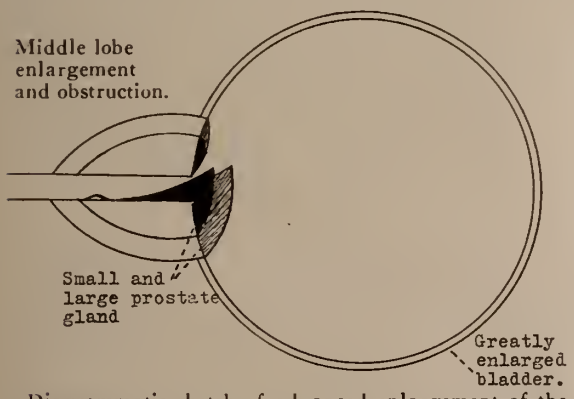
Examination of the lower urinary tract alone is not informative enough to give a complete diagnosis of urinary obstruction. Further examination of the ureters and kidneys can be accomplished by function tests and x-ray. Such additional information is necessary if one wishes to avoid possible future interference from stone, tumor, or other pathology. Functional tests can be easily made in any physician's office by means of phenosulphothalien but more accurate information can be obtained by doing a routine urea



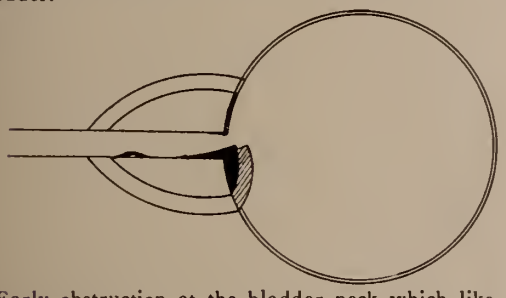
This diagrammatic sketch of the prostate gland, bladder and urethra illustrates the same degree of bladder neck obstruction which may be seen in either a small or a large gland. Both glands may present the same amount of lateral lobe tissue within the posterior urethra.

The shaded areas indicate the advancement of tissue within the urethra. Either gland may eventually cause hypertrophy of the bladder musculature.

clearance time test in all cases of obstruction. Urea clearance will give an indication of early impairment of renal function before either blood urea or phenosulphothalien indicate any damage to kidney structure. Blood urea values may be compared to those of urea clearance at the time of urea clearance estimation without additional trouble. In advanced cases of obstruction the urea clearance time will show values below 50, indicative of renal impairment before the blood urea has increased more than a few milligrams. In early cases and in infected cases the urea clearance will be lowered before there is any change in blood urea.



Diagrammatic sketch of advanced enlargement of the prostate gland causing obstruction to the flow of urine at the bladder neck and resulting in hypertrophy of the bladder.



Early obstruction at the bladder neck which like the above drawing shows the same type of obstruction in both a small and a large prostate gland.

Rectal examination of the prostate gland cannot be depended upon to yield information regarding the contour of the intraurethral part of the gland. It will give some idea as to the size of the gland, but it cannot be used as a diagnostic measure of urinary obstruction. In cancer, rectal examination is of much value because it gives the examiner some idea as to the extent of the malignant process, but bladder pathology can only be guessed at without direct inspection. Massage will show whether the gland is infected or not and perhaps indicate the source of febrile reaction.

Following cystoscopy occasionally a patient will show some improvement in his urinary stream. This is mostly a temporary condition, although the patient often thinks he is well. The same thing frequently occurs after the passage of a catheter. To temporize with a definite obstruction at this point is only to encourage impairment of renal function, retention, and infection. The modern throat specialists do not encourage a patient to keep his tonsils after definite evidence of infection. The abdominal surgeon no longer hesitates to remove an appendix that might possibly rupture at some unexpected moment. The cancer specialists look upon all suspicious lesions and advise early removal to prevent later disaster. In obstruction from prostatic hypertrophy we are dealing with a new growth. This growth is a very definite part of the prostate gland. It prevents adequate and complete urination. If we wish to do the best for our patients who suffer from prostatic obstruction, we can advise those measures which will prevent further embarrassment of the renal mechanism and protect the future of the kidney function. If the patient is fully warned of his condition and advised as to the probable outcome and refuses any means of operative relief, then supportive and helpful measures are the best to be offered.

Prostatic massage will help relieve an infected non-draining prostate but it will not reduce a new growth; neither will any other type of palliative procedure. Massage will not remove a wart on the face or a growth of the prostate gland. Daily enemas and laxatives help relieve pressure upon a sore and distressed gland. Hot sitz baths and rectal irrigations many times soothe the burning and ease the tenesmus from frequent urination. Temperance in all things must be followed to prevent the retention which so often follows neglected prostatic obstruction.

When complete retention does occur, it is more often from sudden failure of the bladder to force the urine through a small opening than it is from the opening itself suddenly becoming closed. Sometimes one catheterization of the bladder will be all that is necessary at that particular time, and the individual will go many months before the retention recurs. If catheterization becomes a matter of regular necessity, then infection usually follows. Such an infection is difficult to control with the available urinary antiseptics. A retention catheter and free drainage will do much to relieve infection, although it must be changed often enough to pre-

vent a chronic urethritis and inflammation of the meatus. While retention used to be looked upon as a condition which required many hours of gradual decompression, now decompression of the bladder is performed within a much shorter time and the ill effects are no worse from rapid relief of acute retention than they are from gradual and painstaking decompression. Water is best restricted late in the day and seems to help the patient get the rest that he needs so much at night. At other times he drinks freely and frequently enough to dilute the products of residual urine within his bladder.

If residual urine is allowed to occur in all cases of obstruction before any kind of operative relief is considered as indicated, then undoubtedly many individuals will pass into a state of neglect. Such a condition is advanced and will only court infection of the entire urinary tract. On the other hand there are cases of early obstruction that may remain in just such a stage of prostatic enlargement that never will get better or worse. It is these cases that must be handled with common sense and judgment. To advise everyone with a small stream to have a complete resection of the prostate gland would be to assume the role of an alarmist, but on the other hand to assure him he will never become worse is just as bad. In these cases there is a difference of opinion as to the best procedure. Perhaps, the safest method is to continue observation of this particular individual over a period of several weeks with the hope that additional information will help determine the best course to pursue.

Of late, preliminary coagulation of the inflamed mucosa overlying the enlargement responsible for obstruction has proved to give relief. In some cases it will give permanent relief from obstruction. In others it prepares the way for resection and appears to lessen the postoperative complications after resection. Such a procedure without later resection in advanced enlargement would be only a false hope; neither would it give permanent relief in a progressive growth of early hypertrophy though it offers some advantage in an early inflammatory condition of the mucosa where obstruction at best is only temporary. Whether this type of treatment will favorably influence an infection of the prostate gland and help produce sterilization of the mucosa and the deeper structures of the prostate gland will yet remain to be seen.

SUMMARY

Obstruction to the flow of urine may be caused by either a small or a large prostate gland. The degree of obstruction depends upon the size of the opening at the bladder neck, and either type of gland may produce the same amount of interference to urination. Early obstruction is first noticed by a decrease in the size and force of the stream. Advanced obstruction begins where early obstruction leaves off, and the symptoms become more severe with straining and residual urine. Treatment consists of early operation and complete removal of all obstruction. Where treatment is refused palliative measures may give some relief but no hopes of cure. Modern methods of diagnosis should discover obstruction in the early stage and protect the individual's health by relief of obstruction to the flow of urine.

TREATMENT OF EYE DISEASES BY THE GENERAL PRACTITIONER*

Ralph E. Russell, M.D.,
Ocala.

In attempting a discussion of this kind, every physician must realize that, due to the scope of the particular field, this paper must deal with only the more common diseases of the eye very briefly, and in some way approach an academic discussion. The average course in ophthalmology offered in medical schools is somewhat elementary, as it justly should be, but in many cases the young physician is given just enough superficial knowledge of the eye to lead him into dangerous pitfalls of mistaken diagnosis and enthusiastic treatment. It is the purpose of this paper, in a general way, to help the general practitioner to recognize those conditions of the eye that he should not attempt to treat, and also give some helpful advice on treatment for simple diseases of the eye, and temporary handling of emergencies.

The armamentarium of the general practitioner when treating the diseases of the eye is often very limited, yet there are many times when the burden of all treatment falls upon the family physician.

The most common disease of the eye that the family physician is called on to treat is acute conjunctivitis. The average case will usually run its course and ultimately result in spontaneous recovery, whether in spite of, or on account of, the various eye drops and lotions that are used. Argyrol or some similar form of mild silver

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the S.S. "Florida", April 27, 28 and 29, 1936.

protein is the main stay of the average physician, as well as the laity. You, of course, realize that there are various types of bacteria causing an acute conjunctivitis and that, for best results, varying treatments are necessary. However, an excellent rule to remember is to use only two drugs in the treatment of acute conjunctivitis. Protargol is probably the strongest and most efficient of all silver protein preparations. It is fairly stable and available practically everywhere. Each of you have, no doubt, often used this drug in strengths of ¼% or ½% for the treatment of acute urethritis and it will perhaps surprise you when I say that from 3% to 5% solution used in the eye every 2 or 3 hours is very efficacious and well tolerated by the patient. Another excellent drug that is well known to every physician, as well as to the manufacturers of numerous patent eye drops, is zinc sulphate. A solution containing 1 or 2 grains of zinc sulphate to the ounce of water or boric acid solution will be found extremely valuable in the treatment of those types of conjunctivitis that tend to become chronic, or those which in the early stages show signs of excoriation around the outer angle of the eye. Many prescriptions for the above and other excellent drugs are written with directions to use 3 or 4 times a day. The patient, of course, has an idea that the drops prescribed by the doctor have some magical power and should quickly clear up the most violent infection, regardless of any other care of the eye. Many patients will use the eye drops several times a day in an eye with the conjunctival sac filled with purulent discharge and blissfully go to bed, sleep all night, and awaken the next morning with the lids glued tightly together, wondering why the eyes have not improved over night. We cannot expect the patients to know it, but we, as physicians, do know that the bacteria do not go to sleep with the patient but that they work untiringly 24 hours a day. In other words, it is a safe guess that any type of conjunctivitis will recover in half the ususal time if the proper treatment is carried on intensively every 2 or 3 hours day and night. In any inflammatory and purulent condition of the body, it is the custom of physicians to remove pus, to cleanse tissue before applying the treatment, but this is often a sadly neglected detail in the treatment of conjunctivitis. Medication should never be put in an eye until that eye is thoroughly cleansed of all purulent exudate. Normal saline, boric acid solution, sodium borate solution, are excellent cleansing agents and should be used freely and often and, contrary to popular belief, an ice cold solution is more efficacious and gratifying to the patient than a hot solution. Heat is used for diseases of the lids only when there is a definite cellulitis of the deeper lid structures. I cannot stress too much the importance of the cold irrigations. In fact, many cases of acute gonorrheal conjunctivitis have been quickly and thoroughly cured with nothing more than cold saline irrigations every 30 minutes 24 hours a day.

Another minor disease of the lids that is often seen by the general practitioner is the common sty or hordeolum. Very often it may be the indirect result of a refractive error that only the proper glasses will permanently correct, but often it is primarily a local infection of the hair follicle. Applications of heat, as in any condition of supperative cellulitis, should always be used and the universally popular yellow oxide of mercury ophthalmic ointment. Personally, I use a 3% ammoniated mercury ophthalmic ointment and believe it to have more antiseptic value than the yellow oxide. The point that I wish to put over to you is that the medication does not cure the sty that is already present, but it prevents the development of others, and therefore should be used for several days after the patient presumes that the first infection is well.

The next most common ophthalmic condition that the family physician is usually called on to relieve is the presence of foreign bodies in the eye. Almost always in every foreign body case, there has already been several amateur efforts by friends and relatives to remove the foreign body. Those foreign bodies that are loose beneath the lids are fairly simple to remove, and this is easily done by the general practitioner. Clean cotton wrapped around a match or toothpick is the best instrument, and it is usually wise to cleanse the eye afterward with some mild irrigating solution. Very few, if any, physicians except ophthalmologists, are equipped to remove foreign bodies that are imbedded in or penetrate the eye. Many very violent corneal ulcers are caused by clumsy and denuding efforts to remove a foreign body from the cornea with a poor light and improper instruments. Eye injuries, with or without foreign bodies, should almost invariably be handled by the ophthalmologist if possible. However, in most cases it is the general practitioner who must administer first aid. In any injury to the eye where there is no obvious penetrating

wound, the most common finding is an abrasion of the cornea. It is practically impossible to see a minor abrasion of the cornea without staining with some dye and the eye often appears uninjured although the patient complains of lacrimation, photophobia and a scratching sensation. Never look at an eye and because the eye looks all right and no foreign body is seen, dismiss the patient with a laugh and a pat on the shoulder, telling him that it will be all right in a day or two. Only luck and the powers of outraged nature will prevent a corneal ulcer or other serious complications. There are innumerable accidents that can befall an eye and the best and safest first aid treatment in practically every eye injury is to cleanse the eye with a mild irrigating solution, immobilize the lids with a bandage, and let the ophthalmologist take the responsibility. In extremely painful injuries, morphine hypodermically, or any other suitable drug should, of course, be used. Cocaine should not be used in the eye following injury because of its devitalizing influence. There are other local anesthetics that will relieve pain temporarily which are not harmful. Butyn, 2%, and pantocaine, ½%, are two of these.

I will not go into a discussion of diseases of the eye that involve the inner structures as they are not in any way within the field of the general practitioner. I now come to the main point that I wish to put over in this paper. It might be said in a few words, as follows: *Never use atropine in the eye.* Atropine is one of the most valuable and helpful drugs in many fields of medicine. It is a powerful drug. It is a dangerous drug. Its effects are many and diversified. Its pharmacological action is local as well as general. The effective dose is sometimes almost infinitesimal. For example: Place a drop of 1% atropine in the eye of a dog. Six hours later place one drop of the dog's urine in another dog's eye and it will dilate the pupil. Atropine and drugs of a similar nature that cause dilation of the pupil by either paralysis or stimulation are practically indispensible to the ophthalmologist when used at the proper time for the proper condition but are the most vicious, most disastrous, and most dangerous drugs when used in an eye where contraindicated. There is no excuse for the improper use of atropine in the eye, but, sad to say, its use has been greatly abused and many innocent victims of well-meaning but erring doctors are hopelessly blind. In my own practice during the past 2 years, I have seen 3 patients with eyes that were absolutely ruined by the use of atropine. These 3 patients had been treated by a general practitioner for acute iritis. Each one was suffering from a violent attack of inflammatory glaucoma that was greatly exaggerated and the eye irreparably damaged by the mydriatic effect of atropine.

Glaucoma can be justly classified as a malignant disease of the eye. It has been said that once afflicted with glaucoma, always a glaucoma patient. This disease, of practically unknown etiology, may attack all ages, all races, of either sex and, contrary to popular opinion among physicians, it is one of the common diseases of the eye. It is an insidious disease. It is a treacherous disease. It may come on suddenly with excruciating pain, loss of vision, and violent congestion of the eye, or it may develop slowly, without warning, without pain. There may be only a gradual diminution of vision which the patient may think is due to age or need of glasses. It may be present in its first stages without symptoms, without diminution of vision, and one drop of atropine solution may be the spark to start a violent conflagration of inflamatory reaction that leaves the patient with a marble-hard, hopelessly blind eye. At best, under ideal circumstances and the most modern surgical and medical treatment, the prognosis of glaucoma is oftentimes unsatisfactory to the patient as well as the physician. This is one disease where little things mean a great deal and those patients afflicted with this pseudo-malignant disease deserve the utmost consideration, profound judgment and skillful treatment. There are many diseases of the eye that, to the casual observer and at times the trained ophthalmologist, very closely resemble glaucoma. The deciding points in the diagnosis are often fine as well as technical. Acute glaucoma may have every physical finding of acute iritis or acute keratitis and the only deciding factor is the intra-ocular pressure. A sensitive and trained finger can usually detect this by palpation but only the tonometer, in the hands of the ophthalmologist should be relied upon. In iritis and many other diseases of the eye, atropine is the backbone of the treatment and in glaucoma it is a poisonous and destructive agent.

What I have just told you is no doubt of an academic nature. There is probably no one among you who was not told the same things in school, but the fact remains that there are many people who have lost their useful vision through the injudicious treatment of a serious disease

of the eye. I feel that this paper will have served its purpose if it saves the vision of only one eye in the State of Florida, but I sincerely hope that the few points covered will make every one of you think twice when handling the most minor condition of the eye, and always conscientiously give the patient the benefit of any doubt and never use anything in the eye without a definitely scientific, accurate, and logical reason.

DISCUSSION

Dr. S. B. Forbes, Tampa:

I wish to compliment Dr. Russell on his very practical paper. In the main, I agree with all of his ideas.

In the treatment of acute conjunctivitis, in addition to the protargol and zinc solutions mentioned, I use a great deal of mercury-oxycyanide in 1-4000 to 1-5000 strength. It is well to keep the lid margins well lubricated with some ophthalmic ointment such as boric acid to prevent retention of secretion, particularly during sleep. In the later stages of conjunctivitis it is a good procedure to brush the lids gently with a 1% silver nitrate solution followed by a thorough flushing with normal saline. With considerable purulent secretion, in conjunctival infection, a smear should be made at once, thereby ruling out a gonococcal infection. Time is a very important factor in these cases for, with early treatment by competent ophthalmologists, the results in gonorrheal conjunctivitis are frequently bad. In only the past week I have seen the dreaded pneumococcal ulcer of the corena in a case of neglected acute conjunctivitis.

In hordeolae of the recurrent type, a real cleansing of the lid margins around the roots of the lashes should be done daily. A tooth-pick wrapped with cotton saturated with peroxide or even soapy water may be used. At the same time the whole region should be scrubbed with soap and water. I am very partial to the ammoniated mercury ointment, but in addition have been using staphylojel, staphylococcic bacteriophage, or toxoid locally. The efficacy of these, however, is doubted by many. In obstinate cases an injection of stock staphylococcus bacteriophage has been used with good results. In a few cases autogenous vaccine was necessary. In children, recurrent sties are very suggestive of an intestinal disturbance. This should be checked carefully. A high vitamin diet in children certainly benefits this type of case. Lessening the intake of starches and sweets frequently helps. In adults a urine examination is in order and in repeated infections, even a glucose tolerance test. In other words a series of infections around the eyelids calls for a general check-up. I would also suggest not opening a sty too early, as frequently instead of shortening the course, a cellulitic process develops with the disturbance of the surrounding defensive wall.

I agree with the advice given in foreign body work. The careful oculist is checking these cases with the slit lamp, as a high magnification can be obtained. With the ordinary loupe, one may feel that all foreign material has been removed; however on further examination with the corneal microscope, a considerable portion may be found to remain. With complete removal of all of the foreign body, many less infected ulcers, with their unpleasant sequelae, would result. If there is to be some time before the patient can consult the oculist, it is well for the general man to give some foreign protein, unless there are definite contraindications. Dr. Russell is correct in advising some anesthetic beside cocaine. Atropine should rarely be used by the general practitioner, certainly never with a dilated pupil in an inflamed eye. It is frequently difficult on examination by ordinary methods to differentiate an acute inflammatory glaucoma from an iritis or iridocyclitis.

There is one symptom, blepharospasm, which is definitely indicative of involvement of one of the anterior portions of the eye, i.e., corena, iris or ciliary body. Therefore, when a definite lid spasm is found, it is well to refer the case promptly to the oculist, except in the presence of a foreign body easily removed.

Dr. George Cook, Tampa:

I am happy to learn that the oculists are now beginning to look on the nutritional side of these eye infections as well as infections of the nose and sinuses.

The point I want to emphasize is this — Dr. Forbes mentioned in his discussion, high vitamin diet. I would like Dr. Forbes to explain what, in his estimation, constitutes a high vitamin diet.

CONCLUSION (ON REQUEST)

Dr. S. B. Forbes, Tampa:

This is a very embarrassing question for a pediatrition to ask an oculist, "What would constitute a high vitamin diet for a child?"

My idea would be that eight ounces of tomato juice and perhaps one ounce of cod liver oil daily would be sufficient.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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Kenneth A. Morris, M.D. *Jacksonville*
Frazier J. Payton, M.D. *Miami Beach*
John C. McSween, M.D. *Pensacola*
William Y. Sayad, M.D. *West Palm Beach*

COMMITTEE ON PUBLICATION
Walter C. Jones, M.D., Chairman *Miami*
Shaler Richardson, M.D. *Jacksonville*
Herbert E. White, M.D. *St. Augustine*

ARE THE DRUGS YOU PRESCRIBE COUNCIL-PASSED?

The Council on Pharmacy and Chemistry is an integral part of the American Medical Association. It is obvious that each individual doctor cannot investigate and test the many products which are on the market. This is the function of the Council. Hundreds of drugs and foods have been approved by the Council; many have been refused acceptance. As a result, many firms have changed their entire advertising campaign. For example, the manufacturers of certain brands of baby-foods do not show any formula on the labels. Many "accepted" drugs bear the warning: "To be used only under physician's supervision." The firms who advertise in our Journal and those who exhibit at our conventions meet the requirements of the Council. They cooperate *with* the doctors and deserve the cooperation *of* the doctors.

In almost every mail, literature and sample are received from firms whose products have not been approved. Today's mail brought an attractive price list from such a pharmaceutical house, with a very convenient order blank and an offer of a liberal discount for cash. No doubt, each one of our members received a copy and consigned it to the waste basket, knowing the standing of this particular firm.

The Association will supply information on any product. Why not use this service?

NEW AND NONOFFICIAL REMEDIES, 1936

"New and Nonofficial Remedies, 1936" is off the press. This volume contains a list and description of the articles that had been accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1936.

The descriptions of accepted articles are based in part on investigations made by, or under the direction of, the Council and in part on evidence or information supplied by the manufacturer or his agents. Statements made by those commercially interested are examined critically and admitted only when they are supported by other evidence or when they conform to known facts.

A number of articles which appeared in "New and Nonofficial Remedies, 1935" have been omitted by action of the Council because they conflict with the rules that govern the recognition of articles or because their distributors did not present evidence to demonstrate their continued eligibility; some have been omitted because they are no longer produced.

During the year 1936, descriptions of such other medicinal substances as are accepted by the Council for New and Nonofficial Remedies will be published from time to time in the Journal of the American Medical Association and will be reprinted in the form of supplements, which will be sent to those who purchase "New and Nonofficial Remedies, 1936."

CONSTITUTION AND BY-LAWS

This issue of the Journal contains a reproduction of the Constitution and By-Laws of the Association. One new feature is the geographical presentation of the county and councilor districts by the use of an outline map of the State and counties.

Members of the Association who wish to refer to the Association's Constitution and By-Laws should always turn to the November issue of the Journal. When changes are made at an annual meeting, the revised Constitution and By-Laws will be reprinted in the Journal the following November.

HEALTH AND ACCIDENT INSURANCE

Last month there was reproduced in the Journal a letter from Honorable W. V. Knott, Insurance Commissioner, setting forth the fact that the Postal Indemnity Company of Dallas, Texas, which company had circularized the doctors in Florida, was not licensed to do business in this State.

This month we have received a copy of a circular letter mailed to Florida physicians by the World Insurance Company. Again, the Insurance Commissioner was contacted and we have from him the following letter:

"October 14, 1936.

"Florida Medical Association, Inc.,
Jacksonville, Florida.

"Gentlemen:

"Replying to your letter of October 13, the World Insurance Company of Omaha, Nebraska, is not authorized to transact business in this State, and we are unable to give you any information regarding it.

"This Department always advises strongly against insurance in unauthorized companies and associations.

Yours very truly,
W. V. KNOTT,
State Treasurer and
Insurance Commissioner."

STATE NEWS ITEMS

President O. O. Feaster has been the guest speaker at several medical gatherings recently. On October 27, he was on the program of the Florida Midland Medical Association at a meeting held in Plant City. On October 29, he was honor guest of the Pasco-Hernando-Citrus County Medical Society at the formal opening of their new county hospital. Doctor Feaster spent October 31 and November 1 in West Palm Beach in attendance at the Florida Radiological Society. On the evening of November 2, he was in Orlando for the dedication of the Florida Tuberculosis Hospital.

* * *

At the annual meeting of the Staff of St. Vincent's Hospital, Jacksonville, the following officers were elected: Dr. Frederick Waas, president; Dr. A. D. Stollenwerck, vice-president; and Dr. Shaler Richardson, secretary. Dr. Waas will head the surgical department, Dr. Stollenwerck the obstetrical department and Dr. Richardson the ophthalmological department.

Dr. Nelson Pearson, who recently made a trip by air to Dry Tortugas, says that fishing is good there. One can see fish in the water all about the place.

* * *

Dr. Leigh F. Robinson of Ft. Lauderdale has returned from a trip to Chicago and Philadelphia where he attended clinics. While in Philadelphia, Doctor Robinson attended the Congress of the American College of Surgeons.

* * *

Dr. N. C. Pintado, who for many years has practiced in Key West, has moved to Miami where he has opened offices at 412-413 Postal Building.

* * *

Twenty members of the Association attended the Annual Clinical Congress of the American College of Surgeons, held in Philadelphia, October 19-23. Those present from Florida were:

James Lunsford Boone, Jacksonville.
S. Ward Fleming, W. Palm Beach.
M. Jay Flipse, Miami.
Frank D. Gray, Orlando.
Walter C. Jones, Miami.
Charles B. Mabry, Jacksonville.
J. M. Nixon, Panama City.
J. C. Pate, Tampa.
Leigh F. Robinson, Ft. Lauderdale.
W. T. Simpson, Winter Haven.
Vale D. Stone, W. Palm Beach.
H. Marshall Taylor, Jacksonville.
E. H. Teeter, Jacksonville.
George C. Tillman, Gainesville.
Frederick J. Waas, Jacksonville.
J. Ralston Wells, Daytona Beach.
Hugh West, DeLand.
Herbert E. White, St. Augustine.
Rabun H. Williams, Eustis.
A. K. Wilson, Jacksonville.

* * *

Dr. and Mrs. Gordon H. Ira of Jacksonville announce the birth of a daughter, Anis Louise, on Sunday, October 25.

* * *

Dr. Jess V. Cohn of Hollywood announces the removal of his offices from the Bank Building to 207-12 Central Arcade. Doctor Cohn is specializing in neurologic and psychiatric diseases.

* * *

Dr. Clayton Royce of Jacksonville was principal speaker at the local Rotary Club on November 3. His topic was "New Developments in Medical Science."

The article appearing in this issue on "Some Facts Concerning Communicable Diseases", written by Dr. Henry Hanson, was read while he was the State Health Officer of Florida. Doctor Hanson is now in South America as the traveling representative of the Pan American Sanitary Bureau and as Technical Advisor to the health departments of Ecuador and Peru. His work is mainly along anti-plague lines.

* * *

The Gulf Coast Clinical Society held its first annual meeting in Mobile, Ala., October 16-17. The Society was organized early this year by the County Medical Societies in Gulfport, Biloxi, Mobile and Pensacola, and is composed of physicians from Mississippi, Southern Alabama, and Northwest Florida.

The speakers included: Leon J. Menville, New Orleans; John A. Lanford, New Orleans; Willis C. Campbell, Memphis; George R. Livermore, Memphis; Winchell McK. Craig, Rochester, Minn.; Fred H. Albee, New York; Raymond W. McNealy, Chicago; James S. McLester, Birmingham; Lloyd Noland, Birmingham; Louis A. Buie, Rochester, Minn.; Orion O. Feaster, St. Petersburg; Harvey F. Garrison, Jackson, Miss.; and Francis E. LeJeune, New Orleans. The Mobile County Medical Society was host at a banquet Friday evening.

The following officers were elected: Drs. W. R. Meeker, Mobile, President; Chas. LeBarron, Gulfport, President-elect; Herbert Bryans, Pensacola, First Vice-president; J. H. Dodson, Mobile, Second Vice-president; M. A. Lischkoff, Pensacola, Secretary-Treasurer.

* * *

The Georgia Pediatric Society will meet in Atlanta on December 10. Among the outstanding speakers who will appear on the program are: Dr. John A. Toomey, Associate Professor in Pediatrics at Western Reserve University, Cleveland; Dr. Julius H. Hess, Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine; Dr. Henry Helmholz, Head of the Department of Pediatrics of Mayo Clinic; and Dr. W. A. Mulherin of Augusta, assisted by Dr. Alfred Walker of Birmingham and Dr. Lesesne Smith of Spartanburg. The members of the Florida Medical Association are invited to attend this meeting. Further information may be secured by writing the Society, 478 Peachtree Street, N. E., Atlanta, Ga.

The Constitution and By-Laws of the Association will be found in this Journal, beginning on page 236. The map on page 240 gives graphic information as to the location of county and councilor districts.

* * *

Dr. and Mrs. Frank S. Whitman of West Palm Beach returned October 1 from Linville, N. C., where Doctor Whitman was house physician at the Eseeola Inn for the summer. He also spent some time in Asheville doing postgraduate work.

* * *

Dr. and Mrs. E. C. Aurin of Fort Ogden recently returned from a month's vacation spent in Michigan.

* * *

Dr. R. Sam Mosley announces the opening of officers in the Seybold Building, Miami.

* * *

Dr. and Mrs. R. R. Sullivan of Lakeland have returned from a combined vacation and study trip. Doctor Sullivan took postgraduate work in clinical surgery at the Mayo Clinic in Rochester, Minnesota. They then made a short trip through southern Canada.

* * *

Fellowship was recently conferred upon Dr. George E. Beckman of Jacksonville by the International College of Anesthetists at a meeting of the College held in Philadelphia.

* * *

Dr. H. Mason Smith, who has maintained his professional offices in the Tampa Theatre Building for ten years, and Dr. Blackburn W. Lowry, who has maintained his in the Citrus Exchange Building since he began practicing in Tampa twelve years ago, moved into the Citizens Bank Building on November 1. The address of each will be 1019 Citizens Bank Building which will be their joint reception room.

* * *

Dr. Stewart Thompson, business manager of the Association, attended the annual meeting of Secretaries of State Medical Societies, held at the headquarters of the American Medical Association, November 16 and 17.

* * *

Dr. Walter C. Jones of Miami has been spending several weeks in the North, taking postgraduate work in New York and Boston. He expected to attend the meeting of the Southern Medical Association in Baltimore on his return trip.

COMPONENT COUNTY SOCIETIES

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

A regular meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Santa Rosa Hotel in Sebring on October 13. Drs. Spencer A. Folsom and Frank D. Gray of Orlando were honor guests at this meeting. Doctor Folsom presented a paper on "Cardiac Disease" and Doctor Gray's subject for the evening was "Renal Denervation." Both papers were discussed by all members present. Wauchula was selected as the place of the November meeting. Those present, besides guest speakers, were: Doctors Boorom, Brewster, Chandler, Highsmith, Kirkpatrick, McKnight, Martin, Simmons and Weems.

DUVAL COUNTY MEDICAL SOCIETY

THE DUVAL COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1936. THIS SOCIETY, WITH A MEMBERSHIP OF 151, MAY WELL BE PROUD OF ITS ACHIEVEMENT. A GREAT DEAL OF CREDIT IS DUE THE OFFICERS OF THIS SOCIETY: DRS. W. McL. SHAW, PRESIDENT; KENNETH MORRIS, PRESIDENT-ELECT; H. W. PORTER, SECRETARY; AND JOHN W. HAYES, TREASURER. CONGRATULATIONS, DUVAL COUNTY MEDICAL SOCIETY!

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society held its regular meeting October 5 in Eustis. Dr. J. Ralston Wells of Daytona Beach, chairman of the Association's Committee on Public Relations, was guest speaker.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held its two regular meetings during the month of November. On the first Friday of the month, the meeting was held at the Veteran's Hospital, Bay Pines, at 6:30 p. m. Dinner was served, followed by a scientific program which was in charge of the Hospital Staff.

On the third Friday, a dinner meeting was held at the Shrine Club. Dr. H. W. MacDonald was principal speaker and told of his travels. The members of the Pinellas Bar Association were invited to attend this meeting.

The Pinellas County Medical Society held a dinner meeting at the Shrine Club, St. Petersburg, on the evening of October 16. Dr. E. Bryant Woods showed motion pictures on "Associated Operations of Parturition" and "Intracranial Injuries of the New Born."

The Pinellas County Medical Society is setting the pace for 1937. Already, 26 members of that society have paid Association dues for 1937. This is the first society to send in dues for next year. We predict an early 100% rating for this society for 1937.

CONSTITUTION

ARTICLE I.

Name of the Association

The name and title of this organization shall be the Florida Medical Association, Incorporated.

ARTICLE II.

Purposes of the Association

The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar Associations in other States to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests; and to the enlightenment and direction of public opinion in regard to the great problems of State medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III.

Component Societies

Component Societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.

Composition of the Association

Section 1. This Association shall consist of Members, Delegates, Honorary Members, Life Members, and Guests.

Sec. 2. *Members*—The members of this Association shall be the members of the component county medical societies.

Sec. 3. *Delegates*—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

Sec. 4. *Honorary Members*—Honorary and retired members of the Florida Medical Association may be elected by the House of Delegates or by the Executive Committee either directly or upon nomination officially made by a component County Medical Society. An honorary or retired member shall be exempt from all dues in this Association; shall not have the right to vote; shall

be permitted to subscribe for the publication of the Association at a special price to be made by the House of Delegates or Executive Committee; shall have the right to attend meetings and be eligible to such other privileges as may be granted by the House of Delegates.

Sec. 5. *Guests*—Any distinguished physician may become a guest during any Annual Meeting upon invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that Meeting.

Sec. 6. *Life Members*—Any member of the Florida Medical Association who has been an active member of the Association for 35 years shall be made a life member of the Association and exempt from all dues.

Article V.

House of Delegates

The House of Delegates shall be the legislative and business body of the Association, and shall consist of (1) Delegates elected by the component county societies, and (2), *ex-officio*, the officers of the Association as defined in this Constitution.

Article VI.

Meetings and Sessions

Section 1. The Association shall hold an Annual Meeting during which there shall be held daily not less than two Sessions which shall be open to all registered members, delegates, honorary members, life members and guests.

Sec. 2. The Association shall hold an Annual Meeting at the place selected by the House of Delegates at the preceding Annual Meeting. The date shall be fixed by the Executive Committee with the approval of the Committee on Arrangements of the entertaining society at least four months in advance.

Sec. 3. Special Meetings of either the Association or the House of Delegates may be called by the President.

Article VII.

Officers

Section 1. The Officers of this Association are to be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, and an Editor of the Journal. In the discretion of the Association, the offices of Secretary, Treasurer and Editor of the Journal may be held by one individual.

Sec. 2. All Officers are to be elected annually, and shall serve until their successors are elected and installed.

Sec. 3. The Officers of this Association shall be elected by the Association at noon on the last day of the Annual Meeting, and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such an office who is not in attendance during that Annual Meeting (except the Secretary, Treasurer and Editor of the Journal) and who has not been a member of the Association for two years.

Sec. 4. The Journal of the Florida Medical Association, Inc., shall be the official organ of the Association.

Article VIII.

Arrangement for Funds

Funds for meeting expenses of the Association are to be arranged for by the House of Delegates, by an equal per capita assessment on each county society to be fixed by the House of Delegates, or by voluntary contributions or bequests, and by profits of publications. Funds may be provided by the House of Delegates to defray the expenses of the Annual Meetings, for publications, and for such other purposes as it may deem proper.

Article IX.

Referendum

The General Session of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may by a similar vote of its own members, or after a like vote of the General Session, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question, and be binding upon the House of Delegates.

Article X.

The Seal

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

Article XI

Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Meeting, provided that such amendments shall have been presented in open session at the previous Annual Meeting, and shall have been sent officially to each component county society at least two months before the meeting at which final action is to be taken.

BY-LAWS

Chapter I.

Membership

Section 1. All members of Component Societies shall be privileged to attend all sessions and take part in all of the proceedings of the Annual Meeting, and shall be eligible to any office within the gift of the Association.

Sec. 2. The name of a physician upon the properly certified roster of members, or list of delegates, of a component society which has paid its annual assessment, shall be *prima facie* evidence of his right to register at the Annual Meeting in the respective bodies of this Association.

Sec. 3. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take any part in any of its proceedings until such time as he has been relieved of such disability.

Sec. 4. Each member in attendance at the Annual Meeting shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of an Annual Meeting until he has complied with the provisions of this section.

Chapter II.

General Sessions

Section 1. The General Sessions shall include all registered members, delegates, honorary members, life members and guests, who shall have equal rights to participate in the proceedings and discussions and, except honorary members and guests, to vote on pending questions. Each General Session shall be presided over by the President, or in his absence or disability, or by his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the an-

nual address of the President, and the annual oration, and the entire time of the Meeting so far as may be shall be devoted to papers and discussions relating to scientific medicine.

Sec. 2. The General Session shall have authority to create committees or commissions for scientific investigations of special interest and importance to the profession and public, and to receive and dispose of reports of the same, but any expense in connection therewith must first be approved by the House of Delegates or the Executive Committee.

Sec. 3. Except by special vote, the order of exercises, papers and discussions as set forth in the official program shall be followed from day to day until it has been completed.

Sec. 4. No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once, on any one subject.

Sec. 5. All papers read before the Association shall be its property. Each paper shall be deposited with the Secretary when read.

Chapter III.

House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Meeting of the Association, and shall so fix its hours of meeting as not to conflict with the first General Session of the Association, or with the session held for the address of the President and the annual oration, and so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interests of the Association and profession require, it may meet in advance, or remain in session after the final adjournment of the Annual Meeting, or meet at the call of the President.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every 20 members, and one for each major fraction thereof, but each county society holding a charter from this Association, which has made its annual report and paid its assessment as provided in this Constitution and By-Laws, shall be entitled to one delegate. Provided, that this annual report must be made to the Secretary of the State Association at least thirty days prior to the date of the Annual Meeting.

Sec. 3. A majority of the registered delegates shall constitute a quorum, and all of the sessions of the House of Delegates shall be open to members of the Association. Ample seating facilities shall be arranged for the House of Delegates, separate and apart from the seating facilities provided for visiting members of the Association.

Sec. 4. It shall, through its officers, Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping-stone to future ones of higher interest.

Sec. 5. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county of the State who can be made reputable has been brought under medical society influence.

Sec. 7. It shall encourage post-graduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 8. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body in such a manner that not more than one-half, as near as may be, shall be elected in any one year.

Sec. 9. It shall, upon application, provide and issue Charters to county societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 10. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies, and these societies when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 11. It shall divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each a district medical society, and all members of component county societies, and no other, shall be members in such district societies.

Sec. 12. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates, and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Sec. 13. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 14. It shall publish its proceedings in The Journal of the Florida Medical Association, Inc.

Sec. 15. It shall select the place for the next annual meeting.

Sec. 16. Each delegate representing a component society, before being seated, shall deposit with the Association's secretary or his duly authorized representative, a certificate signed by the Secretary of his component society, stating that he has been regularly elected a delegate by the component society. All delegates shall report at the registration desk upon arrival at the state meeting, exhibit their credentials and receive instructions regarding the meeting place and time of House of Delegates.

Chapter IV.

Election of Officers.

All elections shall be by secret ballot, unless there is but one nominee for an office when the Secretary, upon motion duly seconded and carried, is empowered to cast the ballot of the Association for the nominee. A majority of the votes cast shall be necessary to elect.

Chapter V.

Duties of Officers

Section 1. The President shall preside at all meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for; shall deliver an annual address at such time as may be arranged; shall give a deciding vote in case of a tie, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the State and assist the Councilors in building up the county societies, and in making their work more practical and useful.

Sec. 2. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death,

resignation or removal, the First Vice-President shall succeed him. The President-elect shall be *ex-officio* member of all committees, without the power to vote.

Sec. 3. The Treasurer shall give bond in the amount of his yearly budget. He shall demand and receive all funds due the Association, together with bequests and donations, and shall have the care and arrangement of fiscal affairs of the Association. He shall subject his accounts yearly to audit by a Certified Public Accountant, and render an annual report of his doings to the second General Session of the Association. He shall charge upon his books the assessments upon each component county society at the end of the fiscal year, which assessments he shall collect and make the proper credit for, and he shall perform such other duties as may be assigned him. All funds belonging to the Association shall be deposited in a National Bank to the credit of the Association. No money shall be drawn from this account except by proper voucher checks, serially numbered. The expenses of the Treasurer's bond and audit of accounts, shall be paid by the Association.

Sec. 4. The Secretary shall attend all sessions of the Association and of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands. He shall provide for the registration of members and delegates at the Annual Meetings. He shall keep a record of all the legal practitioners of the State, noting their status in relation to their county societies, and upon request shall transmit a copy of this list to the American Medical Association for publication. Insofar as it is in his power, he shall use the printed matter, correspondence and influence of his office to aid the Councilors in the organization and improvement of the county societies and in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He may employ such assistance as may be authorized by the House of Delegates or the Executive Committee. He shall annually make a report of his doings to the second General Session of the Association. In order that the Secretary may be enabled to give that amount of time to his duties which will permit of his becoming proficient, it is desirable that he should receive some compensation. The amount of his salary shall be $600.00 per annum.

Chapter VI.

Council

Section 1. The Council shall consist of one Councilor from each of the following districts: *Councilor District No. 1,* comprising the following counties: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, and Bay. *Councilor District No. 2,* comprising the following counties: Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, and Jefferson. *Councilor District No. 3,* comprising the following counties: Madison, Taylor, Hamilton, Suwannee, Lafayette, Columbia, Dixie and Baker. *Councilor District No. 4,* comprising the following counties: Alachua, Marion, Levy, Citrus, Sumter, Hernando, Pasco, Gilchrist, Bradford and Union. *Councilor District No. 5,* comprising the following counties: Duval, Nassau, Clay, and St. Johns. *Councilor District No. 6,* comprising the following counties: Volusia, Flagler, and Putnam. *Councilor District No. 7,* comprising the following counties: Hillsborough, Pinellas, Manatee, and Sarasoto. *Councilor District No. 8,* comprising the following counties: Polk, Hardee, DeSoto, Highlands, Charlotte, Lee, Glades, Hendry, and Collier. *Councilor District No. 9,* comprising the following counties: Lake, Orange, Osceola, Brevard and Seminole. *Councilor District No. 10,* comprising the following counties: Indian River, Okeechobee, St. Lucie, and Martin. *Councilor District No. 11,* comprising the following counties: Palm Beach and Broward. *Councilor District No. 12,* comprising the following counties: Dade and Monroe.

Upon the adoption of this amendment, the incoming President shall appoint one Councilor for each district, six for one year and six for two years, and thereafter they shall be appointed for two years as the terms expire. The Councilors shall meet immediately after the adjournment of the Annual Meeting and elect their Chairman and a Secretary, and the latter shall keep a record of the proceedings. The Council shall, through its Chairman, make an annual report to the first session of the House of Delegates.

Sec. 2. Each Councilor shall be organizer, peacemaker and censor for his district. He is urged to visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each annual session of the Council.

Sec. 3. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates, or the general sessions, must originate in the county society and shall be referred to the Council without discussion.

Chapter VII

Committees

Section 1. Regular Committees shall be the Executive Committee (or may be called the Board of Governors) (Sec. 2); A Committee on Scientific Work (Sec. 3); a Committee on Legislation and Public Policy (Sec. 4); a Committee on Publication (Sec. 5); a Committee on Arrangements (Sec. 6); a Committee on Medical Education and Hospitals (Sec. 7); a Committee on Public Relations (Sec. 8); a Committee on Necrology (Sec. 9); a Committee on Medical Post-Graduate Course (Sec. 10); a Committee on Cancer Control (Sec. 11); a Committee on Medical Economics (Sec. 12); Inter-relationship Committee (to work with similar committees from allied professions—dentists, druggists and nurses) (Sec. 13); a Committee on Tuberculosis and Public Health (Sec. 14); a Committee on State Controlled Medical Institutions (Florida State Hospital and Florida Farm Colony) (Sec. 15); a Committee on Maternal Welfare (Sec. 16); and an Advisory Committee to the Woman's Auxiliary (Sec. 17). They shall be appointed by the President as hereinafter prescribed.

The Florida Medical Association shall be divided into six committee districts as follows: Northwest, North Central, Northeast, Southwest, South Central and Southeast districts. The *Northwest District* (A) to include the following counties: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, and Jefferson. The *North Central District* (B) to include Madison, Taylor, Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Baker, Union, Bradford, Alachua, Marion, Citrus, Sumter, Hernando, and Pasco Counties. The *Northeast District* (C) to include Nassau, Duval, Clay, St. Johns, Putnam, Flagler, and Volusia Counties. The *Southwest District* (D) to include Hillsborough, Pinellas, Manatee, Sarasota, Polk, Hardee, DeSoto, Charlotte, Lee, Highlands, Glades, Hendry, and Collier Counties. The *South Central District* (E) to include Lake, Orange, Seminole, Osceola, Brevard, Indian River, Okeechobee, St. Lucie, and Martin Counties. The *Southeast District* (F) to include Palm Beach, Broward, Dade and Monroe Counties.

Sec. 2. The Executive Committee (or Board of Governors) shall consist of the President and Secretary,

ex-officio, and six members, one from each district, to be appointed by the President. Upon the adoption of this amendment to the By-Laws, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereafter they shall be appointed for three years as the terms expire. This committee shall meet immediately after the adjournment of the Annual Meeting and elect their Chairman. It shall consider and act upon all matters of business pertaining to the Association in the interval between the annual meetings, and shall render a report of its actions to the Second General Session.

Sec. 3. The Committee on Scientific Work shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years and thereafter they shall be appointed for three years as the terms expire. This committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. It shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions in the Constitution and By-Laws. It shall prepare and issue a program for each Annual Meeting, announcing the order in which papers, discussions, and other business shall be presented. The number of papers to be read before each Annual Meeting shall be left to the discretion of the Committee on Scientific Work, but no member shall be permitted to present a paper in successive years.

Sec. 4. The Committee on Legislation and Public Policy shall consist of the President and Secretary, *ex-officio,* and six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years and thereafter, they shall be appointed for three years as the terms expire. Under



COMMITTEE AND COUNCILOR DISTRICTS

A—Northwest

Councilor, No. 1
- Bay
- Escambia
- Holmes
- Okaloosa
- Santa Rosa
- Walton
- Washington

Councilor, No. 2
- Calhoun
- Franklin
- Gadsden
- Gulf
- Jackson
- Jefferson
- Leon
- Liberty
- Wakulla

B—North Central

Councilor, No. 3.
- Baker
- Columbia
- Dixie
- Hamilton
- Lafayette
- Madison
- Suwannee
- Taylor

Councilor, No. 4.
- Alachua
- Bradford
- Citrus
- Gilchrist
- Hernando
- Levy
- Marion
- Pasco
- Sumter
- Union

C—Northeast

Councilor, No. 5
- Clay
- Duval
- Nassau
- St. Johns

Councilor, No. 6.
- Flagler
- Putnam
- Volusia

D—Southwest

Councilor, No. 7.
- Hillsborough
- Manatee
- Pinellas
- Sarasota

Councilor, No. 8.
- Charlotte
- Collier
- DeSoto
- Glades
- Hardee
- Hendry
- Highlands
- Lee
- Polk

E—South Central

Councilor, No. 9.
- Brevard
- Lake
- Orange
- Osceola
- Seminole

Councilor, No. 10.
- Indian River
- Martin
- Okeechobee
- St. Lucie

F—Southeastern

Councilor, No. 11.
- Broward
- Palm Beach

Councilor, No. 12.
- Dade
- Monroe

the direction of the House of Delegates, it shall represent the Association in securing and enforcing legislation in the interest of public health and scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall use every organized influence of the profession to promote the general influence in local, state, and national affairs and elections. Its work shall be done with the dignity becoming a great profession, and with that wisdom which will make effective its powers and influence. It shall have the authority to be heard before the entire Association upon questions of great concern at such time as may be arranged during the Annual Meeting.

Sec. 5. The Committee on Publication shall consist of the Editor and two others to be appointed by the President, and shall have referred to it all reports on scientific subjects and all scientific papers and discussions heard before the Association. It shall be empowered to curtail or abstract papers and discussions, and any paper referred to it which may not be suitable for publication may be returned to the author. All papers read before the Association shall be the property of the Association. The Editor shall receive an annual salary of $600.00, provided that this be paid out of the funds of The Journal.

Sec. 6. The Committee on Arrangements shall consist of the component society in the territory in which the Annual Meeting is to be held. It shall, by committees of its own selection, provide suitable accommodations for the meeting-places of the Association and of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its Chairman shall report an outline of the arrangements to the Secretary for publication in the program, and shall make additional announcements during the meeting as occasion may require.

Sec. 7. The Committee on Medical Education and Hospitals shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall serve in this State for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

Sec. 8. The Committee on Public Relations shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. The duties of this Committee shall be to promote friendly relations between this Association and the public, to encourage the propogation of proper medical information to the public, either by publication, radio broadcasts, or talks before community gatherings, the same being censored or controlled by the Florida Medical Association or its component societies.

Sec. 9. The Committee on Necrology shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall see that a record and biographical sketch of all deceased members is properly recorded in the annals of the Florida Medical Association, and that suitable resolutions are published in its Journal.

Sec. 10. The Committee on Medical Post-Graduate Course shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members, two for one year, two for two years, and two for three years, an thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall confer with the officers of the University of Florida and arrange the schedule of a one week's Post-Graduate course, to be held annually at the University of Florida at Gainesville. It shall have the power to select the faculty from outstanding medical educators in the United States and make other arrangements necessary for its proper conduction, such as the time, various courses, and the fees to be charged.

Sec. 11. The Committee on Cancer Control shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall cooperate with the Dr. John Gorrie Memorial Foundation and the Council on Cancer Control of the American Medical Association.

Sec. 12. The Committee on Medical Economics shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall obtain all information relative to medical economic conditions in this State in general.

Sec. 13. The Committee on Inter-relationship shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall work with like committees from allied professions—as dentists, pharmacists, and nurses—to provide a medium for discussing and taking concerted action on matters of common interest to these allied professions.

Sec. 14. The Committee on Tuberculosis and Public Health shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall cooperate with the Florida Tuberculosis and Health Association.

Sec. 15. The Committee on Florida State Medical Institutions shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall investigate the medical personnel and the medical requirements of all

State or public institutions and recommend such changes and improvements as they deem necessary for the most efficient operation of such institutions.

Sec. 16. The Committee on Maternal Welfare shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. The duties of this Committee shall be such as usually fall upon such a committee.

Sec. 17. The Advisory Committee to the Woman's Auxiliary shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the Annual Meeting and elect its Chairman. This Committee shall advise the Woman's Auxiliary on medical and ethical subjects pertaining to their activities.

Sec. 18. Each Committee shall have a report of its activities to submit to the annual Pre-Convention Meeting, and shall make its final report to the House of Delegates at its first annual session. All reports of committees named in this chapter must be approved by the House of Delegates.

Chapter VIII

Assessments and Expenditures

Section 1. An assessment of $10.00 per capita on the membership of the component societies is hereby made the annual dues of the Association; of this amount $2.50 shall be set up as an Emergency Fund, and $3.00 shall be considered as a subscription for The Journal. The Secretary of each county society shall forward its assessment, together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of this Association thirty days in advance of each Annual Meeting.

Sec. 2. Any county society which fails to pay its assessment, or make the reports required, on or before the date above stated, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 3. All motions or resolutions appropriating money shall specify a definite amount, or so much thereof as may be necessary for the purpose indicated, and must be approved by the House of Delegates on a call of the ayes and naes.

Sec. 4. Any county society shall have authority to remit the dues of its Secretary, to the State Association, for duties performed in accordance with the Constitution and By-Laws.

Chapter IX.

Rules of Conduct

The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

RESOLUTION

Whereas, The rules of conduct as set forth in Chapter IX of the Florida Medical Association, Incorporated, are: "The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public," and,

Whereas, There have sprung up among us various mutual aid societies which render or promise to render medical service for a specified sum, and,

Whereas, These societies actively solicit patients and hire physicians at a fixed rate per month or per patient and thus prevent the free choice of a physician by their clientele, and,

Whereas, This practice is a direct violation of the principles laid down in the Code of Ethics of the American Medical Association, and,

Whereas, This practice constitutes unfair competition and is detrimental to the progress of medical science:

Therefore, Be It Resolved:

1. That the poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.
2. That it is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession. By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or a fixed rate per capita. Specifically, contract practice is unethical: (1) When there is solicitation of patients, directly or indirectly. (2) When there is underbidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of employment make it impossible to render adequate service to the patients. (7) When the contract because of any of its provisions or practical results is contrary to sound public policy.
3. That when a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.
4. That it is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy. It is specifically understood that this does not apply to interns devoting their full time to hospital practice.

Be It Further Resolved: That any member violating any of the provisions of this resolution shall be reported to the Executive Committee of the Florida Medical Association, Inc. It shall be the duty of the Executive Committee to investigate such charges and hear the defense of the members so charged. If the charges be sustained, the Executive Committee shall then recommend to the component medical society of which the charged physician is a member such disciplinary measures as are provided in the By-Laws of the component medical society. If further action seems necessary the Executive

Committee has the power to report its recommendations to the House of Delegates of the Florida Medical Association, Inc., for such further disciplinary measures as are provided in the Constitution and By-Laws of the Florida Medical Association, Inc.

Be It Further Resolved: That upon the passage of this resolution it shall immediately become a part of the By-laws of the Florida Medical Association, Incorporated.

Chapter X.

Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Roberts' Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XI.

County Societies

Section 1. All county societies now in affiliation with this Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, upon application to the Council, receive a charter from and become a component part of this Association.

Sec. 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.

Sec. 3. Charters shall be issued only upon the approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or the spirit of this Constitution and these By-Laws.

Sec. 4. Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the District if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 5. Each county society shall judge of the qualification of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable white and legally registered physician who is practicing, or who will agree to practice, non-sectarian medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

Sec. 6. Any physician who may feel aggrieved by the action of the society of his county in refusing him membership or in suspending or expelling him, shall have the right of appeal to the Council which, upon a majority vote, may permit him to become a member of an adjacent county society.

Sec. 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 8. When a member in good standing in a component society moves to another county in this State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Sec. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Sec. 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Sec. 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official position and other preferments shall be unstintingly given to such members.

Sec. 12. At the time of the annual election of officers each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association, in the proportion of one delegate to each twenty members or major fraction thereof, and the Secretary of the society shall send a list of such delegates to the Secretary of this Association, at least ten days before the Annual Meeting.

Sec. 13. The Secretary of each county society shall keep a roster of its members, and a list of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, thirty days in advance of each Annual Meeting, and at the same time that the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Chapter XII.

Amendments

These By-Laws may be amended at any Annual Meeting by a majority vote of all the Delegates present at that meeting after the amendment has laid upon the table for one day.

MATERNAL AND CHILD HEALTH

A proposed program of the Bureau of Maternal and Child Health of the State Board of Health for the fiscal year July, 1936, to July, 1937, was approved by the Association's Committee on Maternal Welfare and Child Health at its meeting held in Orlando, August 29, 1936. The Association's committee is composed of the following members: Dr. Homer L. Pearson, Chairman; Doctors R. D. Ferguson, James M. Hoffman, T. C. Kenaston, Robert G. Nelson, S. R. Norris, Luther W. Holloway, William W. McKibben, Councill C. Rudolph and W. E. Sinclair. President O. O. Feaster met with the committee. The proposed program includes:

I. *Medical Education.*

A. Motion picture lecture programs.

Six motion picture and lecture programs have been prepared in the field of obstetrics and pediatrics.

These will be available for presentation at any county medical society meeting or hospital staff meeting. The Bureau of Maternal and Child Health has new complete equipment for projection and arrangements for these programs will be made with the Director. It is desired that the local members of the medical societies be prepared to open the discussion on these various topics as they are presented.

B. Refresher Courses.

It has been decided to hold postgraduate instruction, refresher courses, later this year in both the northern and southern portions of the State. According to the consensus of opinion, these courses will take the form of one evening of instruction per week for five or six consecutive weeks in a given district. Two hours out of the four hours of instruction is to be devoted to pediatrics and obstetrics and their allied subjects. In the department of pediatrics, lectures will be provided in otolaryngology and orthopedic surgery. In the department of obstetrics, lectures will be held on the medical complications which might occur during pregnancy, such as cardiac diseases, tuberculosis, etc., and in gynecology, paying particular attention to venereal diseases and obstetrical repair.

C. Library Facilities.

The library facilities of the State Board of Health is prepared to offer assistance to the individual physician who is preparing a paper for his medical society, or who seeks further knowledge about a difficult case or in regard to some disease or symptom complex.

The Director or any of the imported instructors will always be glad to confer with the physician about interesting cases while in that community carrying on postgraduate instruction.

II. *Nursing Education.*

A. Ten nursing institutes are being conducted this fall through the cooperation of the Director of the Bureau of Public Health Nursing. These consist of lectures and motion picture demonstration on obstetrics and pediatrics.

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FRACTURES AND TRAUMATIC SURGERY—Infarmal Practical Caurse; Intensive Ten-Day Caurse starting February 15, 1937.

EAR, NOSE AND THROAT—Infarmal Caurse; Persanal Caurses; Intensive Twa Weeks Caurse starting April, 5, 1937.

OPHTHALMOLOGY—Intensive Twa Weeks Caurse starting April 19, 1937.

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III. *Midwife Education.*

A. Institutes for the midwives will be held in different parts of the State, directly under the supervision of the midwife supervisor and the director of public health nursing.

By holding these midwife institutes in smaller groups, more intimate instruction will be possible and a closer contact with the local nurse and the local medical profession will be established.

IV. *Lay Education.*

A. Cooperation with the Federation of Women's Clubs throughout the State by providing speakers on suitable topics dealing with maternal and child health and by providing programs whereby assistance may be secured for the nursing program from the women's clubs.

B. Speakers will be provided for men's clubs and organizations and for radio programs. All programs presented to the laity will be with the approval of the Committee on Public Relations of the Florida Medical Association, Dr. J. Ralston Wells, Chairman.

C. Motion picture films are being prepared of the various activities of county health units and maternity and well baby clinics which are now in operation in various portions of the State of Florida and will be ready for presentation to the laity.

V. *Organization of Maternity and Well-Baby Clinics.*

A. Maternity Clinics.

Maternity clinics should be held monthly, semi-monthly or weekly for the indigent patients in the county as found necessary.

The county medical society in cooperation with the county health officer (if one be present), will appoint a committee who will have control of the medical personnel of the maternity clinic and will arrange such matters as rotation of service, frequency of the clinics, etc.

A complete physical examination, including vaginal examination and history, at the initial visit by county health physician or by the physician appointed by the county medical society and reimbursed at the rate of $3.50 per hour. Check-up visits must be made every

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Complete text on the above outline will be furnished on request to members of the Florida Medical Association by Dr. E. Bryant Woods, Director of the Bureau of Maternal and Child Health, State Board of Health, Jacksonville.



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This month introduces to you a new Press and Publicity Chairman and I hope you will look carefully at my name and address at the top of this page and realize that is where you are supposed to send all accounts of what your auxiliary is doing. Every Auxiliary member in Florida is interested in knowing what every other Auxiliary is doing and this page is their medium of communication. So please use it for the benefit of others as well as your own.

It is even more helpful to know what other states are doing and this page hopes to bring you occasional highlights of their activities, but we do not have space to give all the details that might be interesting. However, our National Auxiliary publishes a News Letter four times a year to which you may subscribe for one dollar. We hope that the Auxiliaries will be interested enough to subscribe for their press chairmen. If so, send the subscription to Mrs. J. P. Simonds, 25 E. Walton Place, Chicago, Ill.

* * *

The Fall Executive Board Meeting of the Woman's Auxiliary to the Florida Medical Association was held in Orlando, Sept. 27, at the Colonial Orange Court Hotel. This was a joint meeting with the Advisory Committee, preceded by a luncheon at which Mrs. L. C. Ingram, Parliamentarian, was hostess. Mrs. W. W. Harden, President of the Auxiliary, presided and plans for the coming year were discussed by Dr. Gordon Ira, Chairman of the Advisory Committee. Those present were Mrs. Harden, Dr. Ira, Dr. R. D. Ferguson, Ocala; Mrs. S. M. Copeland, president-elect, Jacksonville; Mrs. R. D. Ferguson, secretary-treasurer, Ocala; Mrs. E. W. Veal, historian, Jacksonville, and Mrs. Ingram.

Helpful suggestions from each of the officers and chairmen present enabled the joint boards to

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outline a constructive and educational program for the Woman's Auxiliary. This has been sent out as a charge from the president of the Medical Association, Dr. O. O. Feaster, St. Petersburg, and is in the hands of all county presidents.

Since this charge stresses one particular project for the year, an educational program against tuberculosis in the form of an essay contest for high school students, the direction of this contest will be in the hands of a committee of which Mrs. S. M. Copeland is chairman. As further details are released to county presidents, it is hoped that an active interest will be taken in this project and that such an essay contest will be sponsored by each county Auxiliary.

* * *

A feature of the October meeting of the Duval County Auxiliary was a talk on tuberculosis by Dr. Gordon Ira, Chairman of the Auxiliary Advisory Committee. Dr. Ira said in part: "Is there not a part that your auxiliary can play? Yes, there is. Every one must first realize that tuberculosis can practically be stamped out, just as leprosy is, by proper patient and community management. And where is the most effective place to start an educational program? In the high schools. If high school students can be taught the facts of tuberculosis as a disease, a great stride will have been taken toward the goal of eventually freeing our community of the disease."

The meeting was held at the home of Mrs. O. P. Broadbent, who was assisted by Mrs. J. W. Hayes, Mrs. C. E. Royce, and Mrs. John Mitchell. Mrs. Mitchell, as president, presided over a well-attended meeting.

In his charge to Auxiliaries for this year, Dr. Feaster asked for continued cooperation with the cancer educational program. Under the direction of the Cancer Control Committee of the Florida Medical Association, acting as an Executive Committee, the American Society for the Control of Cancer is organizing a Women's Field Army in Florida. Mrs. J. Ralston Wells of Daytona Beach has been appointed State Commander. The Woman's Auxiliary to the Florida Medical Association is cooperating in this campaign and is a member of the State Division of the Women's organizations. Mrs. E. W. Veal of South Jacksonville, represents the Auxiliary on this Division and also is acting as a vice-commander of District C.

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An organization meeting of the Women's Field Army was held in Orlando on October 17th at which plans were completed under the direction of Mrs. Marjorie B. Illig, Field Representative, who came to Florida especially for this meeting. Further cooperation will be asked of county auxiliaries as the educational program develops.

* * *

The Volusia County Auxiliary met in New Smyrna, Tuesday evening, October 13th. A dinner with the Medical Society preceded the meeting, which was presided over by Mrs. Maximilian Stern, president. The charge from Dr. Feaster was read and discussed.

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Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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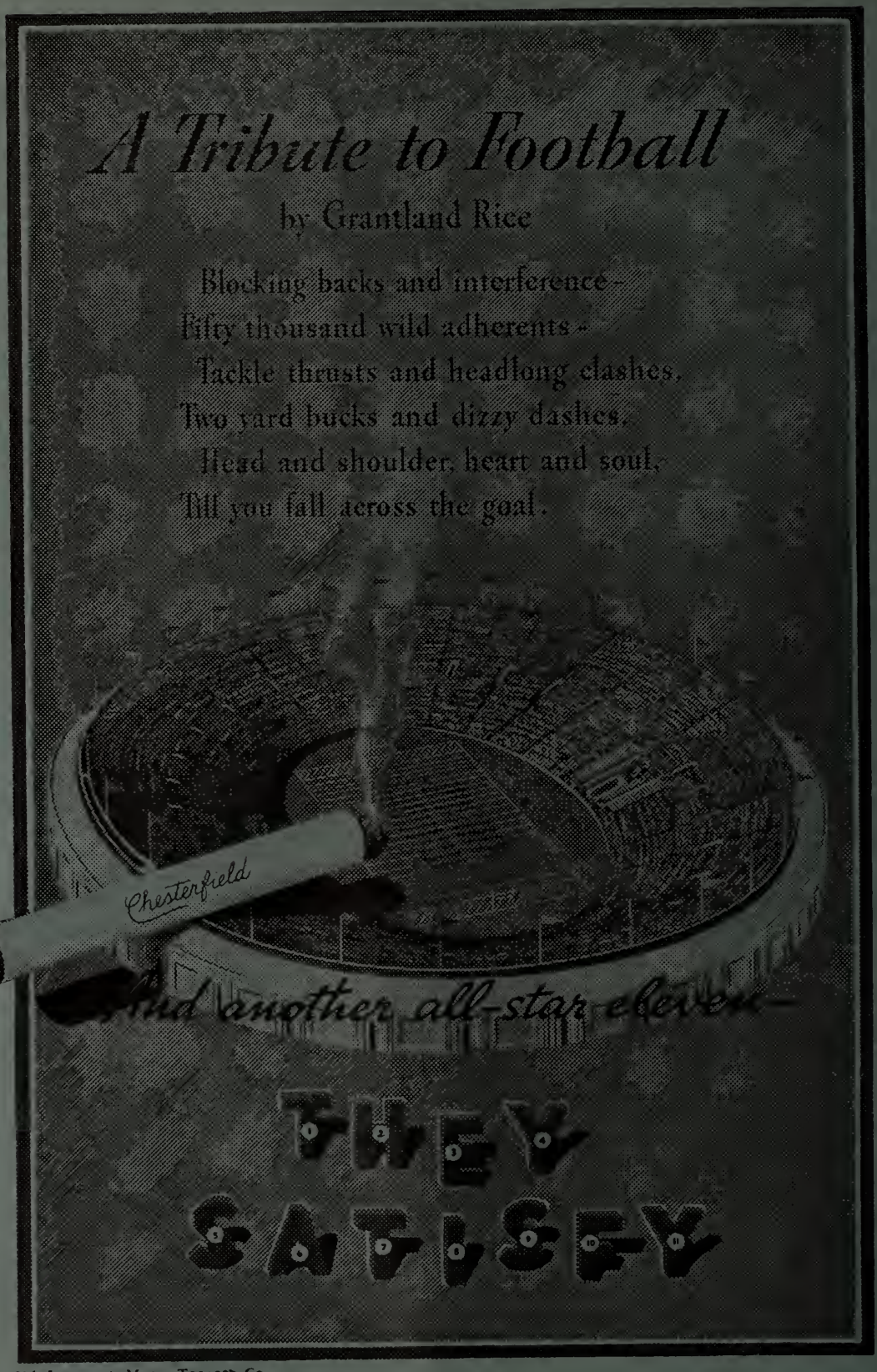
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VOLUME XXIII
NO. 6

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NEXT SESSIONS

Florida Medical Association, St. Petersburg, April 5-6-7, 1937.
American Medical Association, Atlantic City, June 7-11, 1937.
Southern Medical Association, New Orleans, November 30-December 3, 1937.

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(1) 1935. Nutrition Abstracts and Reviews 4, 709.
(2) The Pharmacopoeia of the United States of America, Eleventh Decennial Revision, p. 261.
(3) 1936. Report of the Council, J. Amer. Med. Assoc. 106, 1733.
(4) 1935. J. Assoc. Official Agr. Chem. 18, 610.
(5) 1935. J. Home Econ. 27, 658
(6) 1936. Food Research 1, 223.
(7) 1935. J. Nutrition 9, 667.

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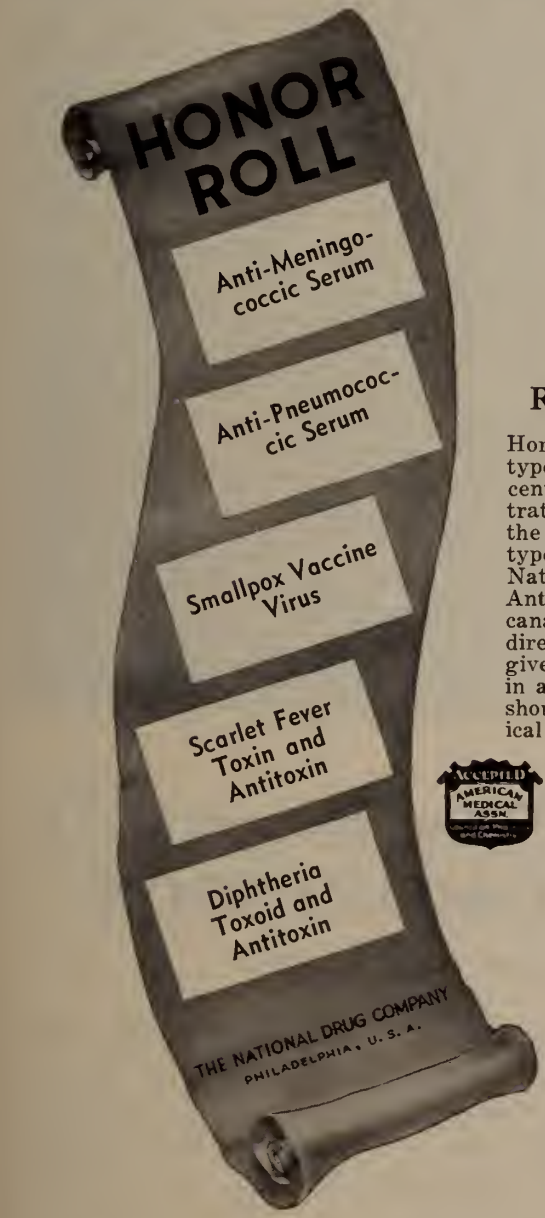
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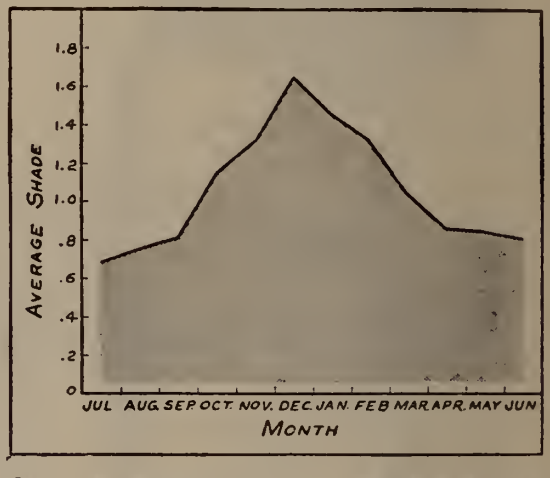
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From American Journal of Public Health—March, 1927

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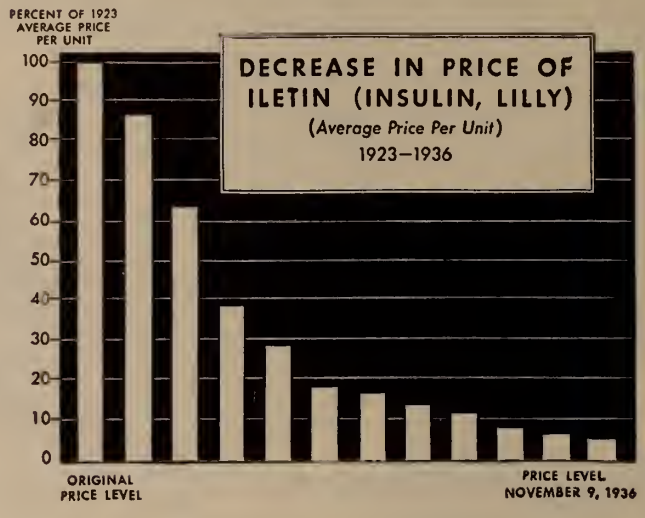
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXIII Jacksonville, Florida, December, 1936 Number 6

BLOODY PLEURAL EFFUSION*

J. Webster Merritt, M.D.,
Jacksonville.

The etiology of a grossly bloody pleural effusion may be quite obscure. To emphasize this point and to open the discussion, a case history is being presented in brief:

T. A. T., a 59-year-old, white, married, American banker-farmer began to feel below par and to lack pep and energy in July, 1935. About three months later, on October 1, he felt a raw, sore, burning sensation in his chest and he began to cough. The following day he developed fever, became nauseated, and vomited. The day following this, he began to raise "hunks" of sputum containing bright red blood which persisted for three days. The cough, expectoration, and fever, however, continued to persist. On October 9 he developed a severe, sticking pain in his right chest, which was made worse by coughing and breathing, and this pain was accompanied by difficult and rapid breathing. At this time he was admitted to the hospital.

Family History: One sister died of carcinoma, age 40. Past History: Patient had always had a marked shoemaker's deformity of the chest.

The significant physical findings were as follows: temperature, 101; pulse, 105; respiration, 28; blood pressure, 125/70. He was a well-developed and well-nourished man lying propped up in bed, breathing in a distressed manner. There was a marked deformity of the chest which formed a concavity just to the right of the sternum and was of such a degree that it seemed as if the anterior chest wall must almost touch the posterior wall in one spot. There were typical signs of fluid under pressure in the right chest, but the examination had to be discounted somewhat because of the deformity. The heart was in the left axillary line.

Course in Hospital: Upon admission the patient was obviously quite ill. The day following admission the x-ray examination of his chest showed evidence of fluid in the right chest and a chest tap was productive of 800 cc. of grossly bloody fluid with a specific gravity of 1020, which was negative for malignant cells and bacilli of tuberculosis. Following the chest tap the patient was relieved both chemically and mechanically. The temperature, pulse, and respiration decreased consistently and appreciably. On the eleventh day in the hospital another chest tap brought forth 1500 cc. of bloody fluid, identical with that just described. The x-ray examination of the chest immediately after the tap was surprising. Now that the fluid had been removed the parenchyma of the lung revealed a large group of coarse, stringy markings in the right lower lobe. The x-ray interpretation was "an acute infection of the lower lobe and pleura which is repairing itself." No changes suggestive of malignancy or tuberculosis were seen. The patient continued to improve symptomatically. His white cell count varied between 7,000 and 10,000. Repeated examinations of the sputum were negative for tuberculosis. Sputum culture and dark field examination were non-contributory, and the plural fluid injected in a guinea-pig produced no lesion. Tuberculins were done and the 1:2000 was found to be positive. On the 30th day in the hospital lipiodol studies showed no evidence of bronchial obstruction. On the 35th day the patient was discharged home in an asymptomatic and greatly improved condition. Since this time he has been seen frequently in the outpatient department over a period of eight months. He has gained about 20 pounds in weight and apparently feels fine.

You ask me what the diagnosis is and I reply that I do not know.

Our departure upon a little journey of differential diagnosis takes for its landmark bloody pleural effusion.

There are a number of causes of bloody pleural effusion which we may consider briefly now, rule out, and pass by. Asthenic conditions such as under-nutrition and scurvy have been mentioned occasionally as the exciting agent, and such conditions as chronic nephritis, cardiac disease, and cirrhosis of the liver are also known to cause a bloody pleural effusion occasionally. However, in the case which has just been presented all of these can be ruled out readily.

The commonest cause of bloody pleural effu-

*Read before the Chattahoochee Valley Medical Association, Radium Springs, Albany, Ga., July 14-15, 1936.

sion is malignancy and it is this one should think of immediately; either malignancy primary in the pleura itself or malignancy which has extended to the pleura from its origin in the bronchus. Because of the symptoms of cough and hemoptysis in this patient, a bronchogenic carcinoma rather than a malignancy primary in the pleura was considered the more likely diagnosis. But the subsequent course has ruled out for us malignancy of any kind. Here is a man who has gained weight and has remained asymptomatic for eight months after discharge from the hospital.

Tuberculosis is the next most common cause of a bloody pleural effusion. However, we all know that a bloody fluid is the exception rather than the rule in tuberculosis. Sero-fibrinous fluid is the typical fluid found in tuberculosis but acute tuberculosis with tubercles on the pleura surrounded by new vascular tissue may give a hemorrhagic fluid. It also is known that a fulminating type of tuberculosis, such as rapidly advancing, tuberculous bronchopneumonia or acute miliary tuberculosis, may cause bloody pleural effusion. Only very rarely are bloody effusions encountered in the chronic or less severe types of tuberculosis. Did this man have tuberculosis? There are a number of points of strong evidence which make this diagnosis untenable: 1. If a patient has a fulminating type of tuberculosis or an acute process, the removal of fluid, which is compressing the lung and giving it rest, is quite apt to cause a progression rather than a regression of the disease. 2. Tuberculosis which is basilar in location is apt to be a progressive or, at best, a persistent process, and, furthermore, the infiltration which was revealed by the x-ray does not appear suggestive of tuberculosis. 3. Tuberculous fluids are apt to reform after removal.

Then what could be the cause of the bloody effusion in this case? We shall not discuss idiopathic bloody pleural effusion for the term means nothing and, in this case, we have evidence of a parenchymal infiltration. Hemorrhagic effusions of an apparently benign origin have been described a number of times. Many years ago Osler referred to a patient who was alive eight years later. The literature is not only scanty but vague in its reference to pneumococcus, streptococcus, and staphylococcus as possible causes of bloody effusion. Because of the type of infiltration in the parenchyma and because of the patient's course since being ill, one is tempted to say that the bloody pleural effusion in the case in question was caused by a nonspecific infection. But if it were due to an infection, one certainly would not expect to find a sterile fluid.

The symptomatology and clinical course in this case were consistent with pulmonary infarct, but it is extremely rare if not impossible to produce a massive bloody effusion.

Thus at the end of our diagnostic journey we find ourselves somewhat up in the air, but although we can not make a definite diagnosis, this case should teach us that a bloody pleural effusion, which connotes malignancy or tuberculosis, may represent a lesion not only non-fatal but relatively benign.

PROGRESS TOWARD LOWER MATERNAL MORBIDITY AND MORTALITY.*

W. C. Roberts, M.D.,
Panama City

First, I would like to express my appreciation and gratitude for being accorded the privilege of presenting this paper. I sincerely hope someone will get some benefit from it.

Second, I want to express my appreciation and gratitude to the physicians from whom I received most of my training. It is to Doctors J. M. McDonald of Tulsa, Oklahoma; Percy W. Tooms and J. R. Reinberger of Memphis, Tennessee, to whom I am indebted for what little I know in this particular field of the practice of medicine. My Chief, the late Percy W. Tooms, was an inspiration to any student who had the honor and privilege to be under his tutelage. In this paper I have referred freely to his teachings and writings in my effort to bring to the minds of our physicians a few items that I consider "food for thought".

In the common experience of mankind ideals are but seldom realized. Were we once to become thoroughly satisfied with what we had attained, all efforts toward future endeavor would be removed. That is why I have chosen progress toward a definite purpose for my subject. Although I hope and believe that progress in this particular field of medicine, and one in which I am chiefly interested, has been great, yet, I am very much aware that perfection is still very far in the future, while the many

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the S.S. "Florida", April 27, 28 and 29, 1936.

unsolved problems which face us at this time call for the exercise of the highest powers of each and everyone of us.

The purpose of this paper is to present some of the factors in the cause of high maternal morbidity and mortality in our state and arouse in you an interest in our fight to save the lives of women who are being sacrificed upon the altar of maternity.

When we review the various statistics of maternal and infant morbidity and mortality for the past hundred years, it is a most remarkable record considering the ignorance of infection, lack of equipment and anesthesia. This is especially noticeable in the early 19th century. Most of the aids now considered essential were unknown then, such as: pelvimetry, laboratory facilities, hospitalization, aseptic technique, x-ray, the modern delivery room, improved emergency measures, immediate repair of lacerations, better knowledge of pathology. Last but not least the internist and the pediatrician are all advances in modern obstetrical practice. Yet, our morbidity and mortality rates compared with those of a century ago are not in keeping with our advance in facilities.

First of all it is pertinent to ask: What are the ideals of obstetrical practice and how may they be approached? It is appropriate here to quote the words of Sir Henry Kellett, a former master of the Rotunda Hospital in Dublin, for a suitable answer to the question, for I do not believe they can be improved upon. Kellett's own words: "The first is to bring a mother safely through a normal pregnancy, labor and puerperium. The second is to insure the delivery of a healthy infant. The third is to leave the mother in as normal condition at the end of the puerperium as she was at the beginning of pregnancy. . . . Similarly there are three basic essentials on which this art is built, knowledge, skill and suitable environment. Knowledge is necessary to avoid both complications and interference, and to treat the one and to regulate the other should it become inevitable. Skill is necessary to obtain the fruits of knowledge. Suitable environment, that is, the circumstances under which a labor takes place, is necessary in order that normal and abnormal events of labor may be conducted in an orderly and aseptic or antiseptic manner."

During the past two or three years we hear especially about the comparatively great maternal and fetal morbidity and mortality rate in our good State of Florida—a rate so high as to make motherhood an infinitely more dangerous occupation than the using or making firearms. If it is indeed safer for a woman to work in a dynamite factory than to bear a child the practice of obstetrics is in a deplorable state of affairs. Surely we should be able to control those factors that tend to produce mortality as well as the manufacturers of explosives control those factors that tend to cause explosions. The serious consideration of this vital problem has now been going on for some time but we have not, as yet, seen any great diminution in the rate of maternal mortality in the State of Florida.

Let us refer back to the "basic essentials" of knowledge, skill and environment as set forth by Sir Henry Kellett, and once we have secured these the noticeable results would seem to follow inevitably. When Flexner made his revolutionizing survey in 1909 of medical education as a whole, the teaching of obstetrics came in for its share of criticism, and has been more or less under fire ever since, yet, the improvement in this division of the medical curriculum has by no means kept pace with other branches of instruction. In 1930 the American Medical Association's Council on Education gave the opinion that there had been a vast improvement in the teaching of obstetrics since the beginning of the present century. They reported that all medical schools giving a four-year course have regular staffs for the teaching of obstetrics that compare favorably with the teaching of surgery. At the time of this report many of the authorities thought the report too rosy a vision of the actual state of affairs. Thus Palmar Findley voiced a dissatisfaction at the time in an article entitled, "The Teaching of Obstetrics and Maternal Mortality". It was his opinion, and no doubt that of some of our older graduates, that over-abundant attention was given to surgery and scant recognition to clinical obstetrics; and it is still the opinion of some of our more recent graduates that there is a very general failure to recognize how important a part of general practice is the obstetrical service the family doctor is called upon to render. We know that more obstetrics is practiced in our state by the family doctor than by the man trained in this specialty and limiting his practice to this field. Therefore, until we get the general practitioner spending a proportionate amount of time in study of the science and art of obstetrics we will see

but little results in lowering the maternal morbidity and mortality rates in our state.

I believe operative obstetrics should be given in special courses just as the refined technique of the various specialties in general surgery are given. Does the general practitioner enter the special field of eye, ear, nose, throat or that of specialized abdominal surgery without special preparation? If he does not, why should he be egotistical or unscrupulous enough to barter human life at its very beginning without proper preparation and knowledge? Yes, it is true that quite a number of our present-day doctors have been denied or have made no effort to attain this knowledge and preparation, but every physician who finds himself confronted with some obstetrical practice should at least be conscientious enough with himself and especially with his patients to refresh his memory with the fundamentals of obstetrics and a knowledge of the mechanism of labor.

Dr. J. R. McCord of Atlanta states that our greatest educational failure is lack of instruction in the mechanism of labor. "With the basic principles of obstetrics thoroughly mastered", he remarks sagely, "the technical details of delivery, whether in the home or in the hospital, are simple and become of minor importance." He goes on to say that the average hospitals of smaller cities and rural communities have few men who are skilled in obstetrics. The general surgeon, confronted with a case of complicated labor, will follow the course of least resistance. But few surgeons have a full knowledge of the mechanism of labor and such knowledge is just as important in the abnormal as the normal case. Thus he is likely to resort to cesarean section without full knowledge or consideration of all the factors involved.

Dr. McCord says:

"Hospitals are not a panacea for bad obstetrics. Results in hospitals, if statistics are to be believed, are quite as deplorable as those in the home, oftentimes, disastrous things happen, patient is, or is not, in a hospital, but how much of the fundamentals of obstetrics does the man *know* who is attending her." It is not my purpose to make an equal comparison of the hospital and the home for maternity, but all things being equal we all know that the hospital is the proper place for deliveries to take place, because in the home, oftentimes, disasterous things happen, while in the hospital where equipment and preparations are better, the same disastrous things would be comparatively easy to cope with.

One may challenge some of the statements in this paper and think that I am trying to bring discredit to my fellow practitioners, but I am only trying to bring to mind the importance of proper medical education in the basic principles of obstetrics. One may say that a very few maternal and fetal deaths occur when a doctor of medicine is in attendance and that our high morbidity and mortality rates are at the hands of midwives or some member of the patient's family. This no doubt is true, but we must remember that the majority of pregnancies and deliveries are normal and spontaneous, occur uneventfully and need no attendant. It is when the situation becomes complicated that a medical attendant is needed and needed badly. To have one that is not versed in the fundamentals, I believe, is worse than none at all, for nature oftentimes corrects complications and ignorant interference would abate rather than abet nature.

In view of the fact that a bigger percentage of the maternal morbidity and mortality deaths in our state is through the hands of midwives, I deem it necessary to comment thereon. Here I again think it appropriate to quote Dr. J. R. McCord, in reporting on the education of midwives at the White House Conference in 1931. Dr. McCord said: "At the present time the midwife is a necessity. She cannot be eliminated in some sections, and every effort should be made by the profession to improve her as rapidly as possible. This improvement should be brought about by local effort; for the training of midwives, which would assure preliminary education and proper training, must be established if present conditions are to be permanently improved. In the sections needing the services of midwives there should be recognized training institutions for them. Here in the south, and particularly in Florida, progress toward lower maternal morbidity and mortality is extensively bound up in the progressive training of these women."

The second basic essential in obtaining lower maternal morbidity and mortality is skill. Skill can be obtained only by the old recipe, which defines genius as an infinite capacity for taking pains. It is not given to everyone nor can everyone acquire the art of being an expert accoucheur, and it is a mistake to think that it is one of the minor requirements for obtaining a medical degree. Any physician who considers his obstetrical practice a burden, or practices it as a

side line, should refrain from it altogether lest he become negligent and fail to practice what he has been taught. As Kellett remarks: "One may find a medical man removing tonsils in the morning with the strictest aseptic technique and a placenta in the evening with none." Obstetrics at present is regarded very generally as a poorly paid and highly exacting task, and an annoying and time consuming feature of general medicine. Thus, oftentimes there is a temptation to use measures to hasten the procedure which, when done without discretion, will surely add to the mortality rate to say nothing of the morbidity rate. These measures that I refer to here are none other than the indiscriminate use of pituitrin; hasty, ungentle and unjustifiable forceps delivery; and neglect of lacerations. A busy physician wants to hurry back to his office or a socially inclined one to get to the party. Here lies the urge to expedite matters by employing improper procedures. No matter how great the physician's skill, it is cast aside in the rush to "get through". The midwife who has no other work to call her is less likely to be unduly influenced, and as a result will often exercise more patience than the medical graduate.

Consideration of the conditions under which most of the obstetrics of our state is conducted brings us to the third basic factor of Kellett's: environment. Puerperal sepsis, still the most prominent cause of maternal mortality and morbidity, is immeasurably reduced by securing the best conditions surrounding a patient going into labor. Yet the strictest asepsis does not always seem to prevent fatality. The cleanest hospital in the world can do very little for the obstetrical patient whose accoucheur is negligent in his technique. Regarding the environment which makes obstetrical emergencies easy to cope with and safe, how many physicians insist that the patient's room be so arranged that if, for example, post-partum hemorrhage occurs, its treatment can be immediately effective. How many practitioners carry with them the necessary appliances and prepare them before hand so that they may be ready for an emergency? And yet, the only real reason for the presence of a medical man during normal labor is that he be available to treat unforseen complications; otherwise he is an additional source of danger. This along with other reasons is why I demand that my cases be delivered in the hospital, even though they be allowed to return home the next day, and I have had patients to return home four hours after delivery. This, I do not advocate as a routine, but in those cases where economies have to be practiced, I think it is relatively safe; at least more so than to risk the undesirable features of most home deliveries. The hospital, aside from being the place where most of the ideals and principles of obstetrical care can be executed, serves as an example to those who are going to care for the patient after she goes home as to the importance and seriousness of the occasion, and creates in their minds the importance of cleanliness, whereas, all the talking one could do would not be so impressive. This is especially true of the small hospitals where the family attendants have occasion to see and hear what is going on. I allow and prefer a member of the family, and especially the one who is going to nurse the patient after she leaves the hospital, just as though they were private nurses, to be present during prepartum, partum, and immediate postpartum care. For it is at this time that impressive orders can be given and the "whys" demonstrated. On the other hand, there is one great adverse circumstance confronting the doctor where members of the family are present at the delivery: the extreme anxiety of the family and the demands of the patient herself that she be relieved of her pain, "to get it over with as soon as possible." I have had, and no doubt everyone of you who does obstetrics has had, husbands, mothers, fathers and patients beg and actually demand that I take the child to relieve the suffering even if it kills the infant. This is often the circumstance unless the patient is resting nicely under the analegesia or anesthesia, and this, my friends cannot always be had. The doctor must be sure of the situation and be just as firm in his demands to the family and to himself. He must hew to the line of his knowledge and teachings, never forgetting that when in great doubt he should request consultation if it is available.

Our teachers diligently emphasize the necessity of asepsis in obstetrics; yet, they claim that a woman with a well-shaved and washed vulva, delivered by a man who wears sterile rubber gloves, understands the mechanism of labor, and makes few or no vaginal examinations, has a better chance of avoiding sepsis, even in the most filthy surroundings, than does the woman whose bed is spotless, but whose doctor is so negligent or lacking in knowledge and skill that he makes frequent vaginal investigations and runs the risk of introducing bacteria into the passage which

no amount of antiseptic solution can ever counterbalance. Environment should not be limited to that in which labor itself is carried out, but also to the surroundings in which pregnancy is passed for these have much to do with success or failure at the crisis. This brings us to the importance of prenatal supervision. In every branch of the practice of medicine the onward success is along lines of prevention. By these measures we can see far ahead and be able to forestall some of the accidents and complications of maternity. Probably fifty per cent of the maternal mortality and morbidity is due to eclampsia. Eclampsia is something we know little about; we know but little about its cause or its treatment, but we do know that the best treatment is prevention, if possible. I dare say that prenatal care properly supervised will prevent 95% of eclampsias. This is but one of the many complications of obstetrics that tend to increase maternal morbidity and mortality rates that could be successfully combated with proper prenatal supervision. Being born is a universal experience, infection with a contagious disease an unlikely accident. What line of preventive medicine should be more important than prevention of maternal mortality and morbidity. It is an accomplishment that commands the mind, heart and hands of every member of our profession. The remotest rural practitioner has the same chance to carry on this great effort for humanity as has the physician with the most modern and up-to-date facilities.

In closing I would like to leave with you a beautiful tribute to motherhood. This writer has said:

"Mother, wife, sister and daughter are the most sacred names on earth.

Mother long since yielding the palm of victory here for the crown of glory there;

Standing wrapped in filmy loveliness between us and Heaven;

Between that mysterious marginal line that separates the finite from the infinite;

Beckons us onward to higher and nobler purposes."

DISCUSSION

Dr. L. M. Rozier, West Palm Beach:

It seems to me that this meeting of the Florida Medical Association has been replete with good things and has brought discussion of a number of things of outstanding importance. Second to none of these is the subject with which this paper is concerned. I am not sure that I can add anything in particular to the very commendable handling of the subject by Dr. Roberts. In his three basic essentials of knowledge, skill and environment, he has described to you a perfect recipe for correcting a situation which as modern physicians we should be ashamed of.

Just how bad the situation is I do not believe even our statisticians are able to tell us. They tell us so many women die, each year, from causes incident to accidents and diseases complicating pregnancy. And we are appalled that such a thing could be true. However, you and I both know that a number of women die every year and that fictitious causes of death are being signed to the death certificates—sometimes even without the fact of pregnancy being mentioned. Of course, these are probably cases of criminal interference. I believe there is going to be a lot of digging down into the statistical figures before we know just what the situation here is—and we cannot know what remedy to apply to the situation until we have fully examined these records.

Rome was not built in a day, and I feel that the men responsible for the maternal welfare committee have started us on a course which if diligently pursued will from year to year disclose to us more and more ways and means of making applications of this knowledge, skill and environment which Dr. Roberts has described to us.

Dr. J. M. Hoffman, Pensacola:

The paper of Dr. Roberts has certainly presented to us a subject which is most timely.

The statistics that were published throughout the country painted a very unfortunate picture, you might say, because they were so widely publicized. A number of things that were in that report were not actually true because of conditions and various other factors there is no use in discussing now. Our own practitioners must bear the burden of finding out what is wrong with our obstetrical practice. I think our maternal mortality rate is much too high.

Dr. Roberts has covered the subject very thoroughly. However, we could discuss details for the rest of the day and still every man would have his own opinion of the various details in which he has succeeded best in his own practice.

There is only one point to bring out in some detail. That is the importance of early diagnosis. You might say that pregnancy is obvious at the

beginning of labor. However, the diagnosis of pregnancy is usually made the first few minutes the doctor sees the patient. But the diagnosis of position is very often overlooked. That is one point that should be kept in mind. When the doctor is called and the woman is starting in labor, an accurate diagnosis of position should be made. Frequently complications can be avoided, and that should tend to lower the mortality rate to a very large extent.

Dr. M. C. Wilson, Miami:

I would like to say just a few words. If you have a case of placenta previa, or a case with a history of postpartum hemorrhage—get the proper donor beforehand. You cannot save her after she has lost most of her blood. Repeated bimonthly examinations as well as urine and blood pressure examinations will prevent a great many eclampsias if diagnosed early and the doctor can do that. And a third thing to do is develop a conscience in the doctor. A doctor who is going to neglect his patient should not do obstetrics. He cannot come back and cure them later. Of course we are going to have some accidental deaths such as laparotomy deaths in surgery. Some will occur in spite of you. But we can lower the mortality rate by careful attention to detail and preparation for an emergency.

The main causes of death are eclampsia, hemorrhage and infection. Other things are of minor consequence. Infection will not occur in your practice very many times. I lost a patient several years ago as a result of abruptio placentae and I could have saved that woman's life if I had had a donor prepared more quickly. I blame myself in that I did not immediately have a donor ready because I knew she had this condition. I take that blame. We should prepare a donor as soon as we suspect the condition, not after hemorrhage occurs.

Avoid vaginal examinations. You can do just as well with rectal examinations in 98% of the cases until the patient is on the table and properly prepared and examine then no higher than is absolutely necessary. Some vaginal infection may be carried into the cervix. Even a rectal examination may be done too often.

Avoidance of using forceps before the cervix is dilated should also be stressed. Some patients come in with torn cervices, and oftentimes the laceration of the cervix is beyond repair going way up into the broad ligament. There is nothing that can be done about this except repair when found. The doctor should have enough conscience not to apply forceps until the cervix is dilated. Wait until that cervix will retract. If you will give the woman time enough for the cervix to retract back over the head you will avoid severe laceration.

CONCLUSION

Dr. W. C. Roberts, Panama City:

Just one more remark.

In trying to do something for the patient, most doctors are too eager to interfere. Nature is the prophylaxis in labor. If you have a normal presentation and a good physical body to deal with your results will be one hundred per cent satisfactory.

STERILITY—DIAGNOSIS AND TREATMENT*

FERDINAND RICHARDS, M.D.,
Jacksonville.

Four years ago I read a paper on "Sterility" before the Florida Medical Association. At that time, I discussed its etiology, classifications, diagnosis and treatment, in both male and female. At this time I wish to discuss it from the gynecological and obstetrical viewpoint, dealing only with the female, bringing to your attention some of its etiological factors, diagnosis and treatment. I wish, also, to emphasize the value of roentgen studies in certain types of cases. The work of Jarco, of New York; of Rubin and Stein, of Chicago; of Phaneuf, of Boston, and of others, constitute outstanding and notable contributions on the subject. The contribution of Dr. Bethel Solomons, of Dublin, Ireland, before the Clinical Congress of the American College of Surgeons in October, 1934, is most instructive and interesting, and is well worth your consideration.

Sterility is a disease and a very serious one, presenting, at times, one of the most baffling problems for the physician. We have all been approached by patients because of a childless marriage. The desire for parenthood, in many people, is one of the strongest instinctive urges. It is my impression that most of the childless couples, who take the trouble to seek a physician's advice, are above the average in intelli-

*Read before the Florida East Coast Medical Association, St. Augustine, Nov. 1, 2, 1935.

gence and in good citizenship. Their desire for parenthood is entirely commendable.

Many cases of sterility can be corrected; others, unfortunately, can not. It is only natural that the gynecologist and obstetrician should be the physicians usually consulted about this problem. Indeed, it is considered by many that the subject of sterility constitutes one of the strongest links between gynecology and obstetrics.

The prevention of sterility by the teachings of the principles of health and hygiene, to young men and women in the premarital state and by making clear the laws of healthy marriage, are very important and are duties in which we must not fail. The time has passed when parents can veil matters of this nature in secrecy, in false modesty or in deceit and ignorance. It is disastrous for parents to wait until their children have attained the teen age before giving proper information about the sexual functions. It is a foregone conclusion that such children have inevitably picked up, on the street and from playmates, false or highly distorted ideas. It is now taught, by many very sane students of the subject, that no child, however young, should be told that babies are brought by the stork. The foundation of sex hygiene should be built with wholesome truth in the earliest years at the time when the child's natural curiosity first begins to assert itself.

I prefer, on this occasion, to present facts and case reports taken from my private practice and hospital services rather than go through the whole gamut of the subject which is available in many modern textbooks and current medical journals. I wish to emphasize the importance of close cooperation with the internist, urologist and pathologist that is so necessary in solving the mystery of many a case of sterility. Most writers agree that about thirty per cent of the cases of sterility are due to the male. I shall not dwell on that point, except to say that when the male is found to be at fault, or even thought to be, he should be sent to a competent urologist at once, before any further consideration is given to the female.

The woman who has been married less than eighteen to twenty-four months, presenting herself as a victim of sterility, should not immediately be considered sterile and should have no gynecological treatment, unless there is definite supporting evidence.

Each patient must be thoroughly and carefully studied. Questions about the general health, habits, sexual and marital relations, as well as the gynecological history, are all important. A complete gynecological examination, as well as special examinations, such as blood studies, especially for syphilis and anemias, the determination of the basal metabolic rate, examination of urine and feces, when indicated, must be made. The elimination of focal infections, such as diseased teeth, tonsils, the appendix, in other words, any constitutional ailment that could very easily be a factor, must be ruled out.

To many of us the role that hormone therapy plays in treating this condition is still disappointing, but probably in the near future will be simplified and more promising. However, the dramatic effect of thyroid extract in cases of sterility, with hypothyroidism and oligomenorrhea, has been observed with much gratification. Diet, especially vitamines and notably vitamin "B" and "E" must not be overlooked.

Stenosis of the vagina, with rigidity, is a well known cause and can, in most instances, be eliminated by using dilation, either manual or mechanical, but when this is accompanied by hysterical vaginismus it is very difficult to treat satisfactorily. Strongly acid and irritating vaginal and cervical discharges have long been recognized as factors in causing sterility. Quite frequently an alkaline douche before intercourse helps to relieve it. The habitual use of chemical contraceptives is known to produce sterility, apart from the immediate contraceptive effect. For example, the repeated use of strong lysol douches and strong bichloride douches is definitely known to produce histological changes in the vaginal mucous membrane. These histological changes are accompanied by alterations of the hydrogen ion concentration of the vaginal secretions in the direction of a greater acidity, which is known to be fatal to the live spermatozoa.

Chronic endocervicitis and cervicitis are causes well known to all of us. The use of the electric cautery and dilators, when accompanied by stenosis, frequently gives excellent results. The removal of thick, tenacious mucus plugs from the cervix is also important. Uterine displacements frequently cause sterility and have been proved to do so by pregnancy occurring after the correction of the displacement. The use of the pessary when possible in posterior displacements, should be thoroughly tried out before resorting to surgery. The auterior displacements are frequently congenital and are associated with hypo-

function and dysmenorrhea. In my opinion, stem pessaries are of little or no value. In selecting a suspension operation, use the one that serves the purpose best. The essential requirement is the selection of a procedure which restores the uterus to its normal position with as little manipulation as possible, thus eliminating such factors as the formation of adhesions, the kinking of the tubes and the dangers of intestinal obstruction. In my experience, I have found the Gilliam and Oldhausen procedures to be entirely satisfactory. It should be pointed out that no dependence, whatever, should be placed on catgut in this work. It is best to use braided silk, double, preferably No. 6.

There is no value in performing a curettage for sterility unless specimens for biopsy are needed. One must admit at times pregnancy occurs after a patient has been dilated and curetted; however, the important factor was the dilation of the cervix, and not the curettage. Uterine fibroids are an important cause of sterility, acting as mechanical impediments, especially if located near the cervix, or may cause ovarian dysfunctions and anemia. Myomectomy, in properly selected cases, has been followed by pregnancy in a high percentage of cases. Some authorities report as high as 33 1/3% success. It is very important to avoid the risk of postoperative adhesions and intestinal obstruction. Every effort must be made to have the scar on the anterior surface of the uterus; if this is impossible, always cover it with an omental graft. Hysterectomy must be chosen when myomectomy appears too great a risk.

Ovarian tumors should be removed when the patient is sterile. Observe, carefully, the patient with mid-menstrual pain. Attempt to rupture the follicle bimanually under an anesthesia, and if this does not cure her, one is justified in opening the abdomen, when all of the other factors are negative. Usually enlarged polycystic or small, flat, spindle-shaped ovaries are found. Either type should be resected. However, some eminent physicians shave the ovary. Either procedure seems to allow easier extrusion of the follicle. Do not hesitate resection of the diseased ovary, or both, if necessary. The writer has a patient who had one ovary and part of the other removed. Since then she has had five successful pregnancies on this piece of ovary. Pelvic adhesions are causes of sterility. All other factors being equal, husband and wife normal, open the abdomen. Adhesions between the tubes and ovaries and broad ligaments or pelvic walls are frequently found interfering with the normal pathway of the ovum into the tube. The separations of these adhesions is followed by pregnancy in a sufficient number of cases to justify this procedure.

Tubal patency is essential for pregnancy to occur, and when it is found that this does not exist, your patient is hopelessly sterile, unless patency can be reestablished. There are many causes for this condition. Gonorrhea stands out as the most common; mixed infections from abortions, appendicitis, perisalpingitis, peritonitis and adhesions, typhoid fever, indirectly, when perforation occurs with resulting peritonitis. The proper care of patients with gonorrhea is most important, but it is not within the province of this paper to discuss the treatment of gonorrhea, except to stress the importance of conservative treatment and resort to every measure possible, before considering surgery. Several years ago I tried to persuade a patient to be operated because of gonorrheal salpingitis. She refused and today has two living children One can never tell what the end results will be, following this infection, and, to be sure, salpingectomy has never cured any woman of gonorrhea. Tuberculous salpingitis does not produce obstruction.

The well known Rubin test, or tubal insufflation as it is commonly called, or the injection of an opaque media, such as iodized oil, into the uterus and tubes, followed immediately by roentgen studies or uterosalpingography are the methods employed in determining tubal patency. The Rubin test is the simpler procedure but not always satisfactory, nor will it always give conclusive evidence of obstruction. The other procedure will, and in addition, it accurately determines the location of the obstruction, which is indeed important in deciding what course of treatment to follow; furthermore, it gives one an indelible record that can not be disputed. In uncomplicated cases, when there is no history of infection, or any condition that would lead one to believe that an obstruction might exist, employ the Rubin test, but if there is the faintest evidence of obstruction or of pelvic pathology, employ uterosalpingography. Quite frequently patients are seen with apparently closed tubes when they are insufflated, but when iodized oil is injected, and the pelvis x-rayed afterward, one

and sometimes both tubes are found to be patent. Contraindications, for all practical purposes, are the same for either procedure, and should be well understood. Never insufflate or inject iodized oil in the presence of acute infections, bloody discharges, debilitating, wasting or organic diseases. The guide for determining activity of chronic infections is the blood sedimentation test. One may also determine the leukocyte and differential blood count, but the former is much more reliable and accurate. The ideal time for this diagnostic study is midway between the periods.

Tubal obstruction at the uterine end and in the mid portion is almost invariably hopeless, while in the outer half and fimbriated end the picture is quite different; therefore, it is to this type of case that I wish to direct your attention and to say that surgery offers the only hope for its cure. In the hands of a competent surgeon a sufficient number of cases have been followed by pregnancy to warrant its use. The Meaker Clinic, in Boston, reports nineteen cases with obstruction in the outer half of the tube that were operated and eleven have been pregnant since then. I do not recommend surgery when the obstruction is in the inner half of the tube, because results, thus far, are entirely too disappointing to warrant its use. I shall not attempt to outline the entire surgical procedure but would suggest that the greatest care, most delicate technique and respect be exercised in performing salpingostomy, if one is to reasonably expect satisfactory results; also, to use either fine linen or silk on a small straight needle, and not catgut. The follow-up care and treatment of these cases is equally as important as the surgery. They must be followed very closely and insufflation be done at monthly intervals for at least six to nine months afterwards. If there is difficulty in keeping the tubes open, they should be insufflated every two weeks. This follow-up treatment can not be too strongly urged, and, in my opinion, if not done, you have utterly failed in your attempt to cure the patient.

Another important test that should always be done is the ovulation test, as outlined by Novak. This is very simple and can be done immediately after insufflation or injection of iodized oil. All that is necessary is to obtain some endometrial scrapings which can be obtained by using a small curette or some other type of special instrument devised for this purpose. Novak and Burch and possibly others, have devised such an instrument. This test is important because, as we all know, the patient who does not ovulate can not become pregnant. Any competent pathologist should be able to recognize secretory changes, occurring in the endometrium, subsequent to ovulation. The endometrium, in this instance, is simply a mirror reflecting the physiological processes occurring after ovulation. Also, the ideal time for this test is midway between the periods.

There is one other condition that I would like to mention, briefly; that is a known cause of sterility, but I am unable to tell you how to treat it. Many a woman is hostile to her husband's spermatozoa. All other factors appear negative, but pregnancy does not take place. This condition has been demonstrated many times when such men and women divorce and each marry again with a resulting fruitful marriage for each.

CASE REPORTS

Case No. 1: Mrs. A. H. M. Age 26 years. Married 3½ years. Never pregnant. No contraceptives used. Husband negative. Insufflation done January 29th, 1930. Tubes opened under pressure at 160 mm. Hg. Became pregnant three months later.

Case No. 2: Mrs. M. C. Age 30 years. Married two years. No contraceptives used. Husband negative. Examination revealed chronic endocervicitis which suggested malignancy. A specimen for biopsy was taken at once. The report was chronic inflammation with gonorrhea. The diplococci were deeply placed in the cervical tissue, while the smears were negative. The cervix was cauterized, and after several months of conservative treatment, it was dilated, gently but thoroughly. Tubal insufflation was not done because of the infection. The patient became pregnant two years later.

Case No. 3: Mrs. R. A. H. Age 22 years. Married four years. No contraceptives used since first year. History of irregular, painful menses four to six weeks apart. B. M. R. minus 15%. Tubes patent. Gynecological examination negative. Given thyroid extract. Menses became regular and less painful. Pregnancy followed four months later.

Case No. 4: Mrs. D. L. P. Age 27 years. Married two and one-half years. Never used contraceptives. Husband negative. Tubes patent as revealed by uterosalpingography. History of long standing colitis and secondary anemia.

R. B. C. 3,430,000. Hb. 68.6%. B. M. R. minus 5%. She was referred to an internist for treatment of the colitis and anemia, which cleared up and seven months later she became pregnant.

Case No. 5: Mrs. C. C. Age 35 years. Married eleven years. No contraceptives used. Husband negative. History of typhoid fever at the age of eleven years, in bed four months. Apparently suffered a perforation which was followed by peritonitis. For the past seven years had been under the care of several physicians because of her sterility and had been insufflated several times. Each time she was told that her tubes were blocked. Bimanual examination revealed a fibroid, about the size of an orange, to the right and forward at the junction of the neck and the body of the uterus. Uterosalpingography showed the right tube closed near the uterine end and the left tube open. Surgery advised.

Case No. 6: Mrs. C. B. S. Age 33 years. Married twice. Last time in 1933. Four pregnancies by first husband. All premature deliveries; none of the babies survived. Bilateral mastectomy for mastitis. Right removed in 1930, left removed in 1933. Present husband negative. Bimanual examination revealed a fibroid at the junction of the neck and body, anteriorly, and a markedly retroverted fundus. Otherwise the examination was negative. Uterosalpingography showed both tubes patent. Myomectomy and Oldhausen suspension done, but pregnancy not advisable for at least six months.

Case No. 7: Mrs. D. G. Age 23 years. Married two and one-half years. Two years previously had an induced abortion at six weeks. History of punctured uterus. Abdomen opened, pelvis filled with blood and fresh adhesions. Five days later developed intestinal obstruction. Reoperated at once. On insufflation both tubes appeared blocked. Uterosalpingography revealed the left tube completely blocked at the uterine end. The right tube allowed a few drops of iodized oil to escape into the culdesac. Because of her past history and surgery, I did not advise that she be operated again.

Case No. 8: Mrs. L. F. D. Age 34 years. Married eight years. Pregnant twice. First time seven years ago. Aborted during an attack of influenza. Four years later had a ruptured left tubal pregnancy. Left tube, ovary and appendix removed. Plastic repair on the right tube. She was first seen by me four years after the surgery. Uterosalpingography revealed a right tubal obstruction at the fimbriated end, with a pronounced hydrosalpinx. On the left there was evidence of iodized oil for a distance of about half an inch, at the site of the salpingectomy. Because of the surgery this patient had had and previous salpingostomy, with no success, I did not advocate further surgical intervention. However, I wish to emphasize that this patient did not have any follow-up therapeutic insufflations. I advised adoption of a baby, which was done.

Case No. 9: Mrs. E. E. H. Age 28 years. Married eight years. Complaint was sterility. Husband was negative. No contraceptives used after first six months. Patient reported that she had been insufflated three times in the past three years before coming to my office and was told each time that her tubes were closed. There was nothing unusual in her history, and the gynecological examination appeared negative. B. M. R. plus 7% and the ovulation test was positive. Uterosalpingography showed the right tube open and the left tube closed at the uterine end. Twenty-two days later and fifteen days after the period, artificial insemination was done. The patient felt perfectly well and missed the next period. Forty-four days later she began to cramp and flow, passing blood and placental tissue. She remained in bed and at the end of a week developed symptoms typical of an acute pelvic infection. Six weeks later, after the infection had subsided and the sedimentation test was normal, the abdomen was opened. The left tube and ovary were bound down and chronically diseased. The right tube was closed at the fimbriated end and there was present a small fibroid, about the size of a peanut, on the anterior surface of the fundus. The left tube and ovary were removed. The right tube was repaired with fine linen on a straight needle and the fibroid removed. Just where this infection came from I was unable to say. No offending organisms were isolated. It is logical to assume that the pregnancy superimposed on the chronic left tube might have been responsible for it becoming active again, thus producing the abortion followed by the acute pelvic infection. This patient has been followed and routinely insufflated. When last seen by me, July 9th, the tube opened at 100 mm. Hg. She was told, at that time, that she might attempt pregnancy again.

THE USE OF PROTAMINE INSULIN IN THE HOSPITAL MANAGEMENT OF DIABETES MELLITUS

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This report is based on clinical observations on twenty-six diabetic patients treated with the new slowly absorbed, and, consequently, slowly acting insulin compound, protamine insulinate. This preparation, originally made and used by Hagedorn, Jensen, Krarup, and Wodstup[1] at the Steno Memorial Hospital, Copenhagen, was the first practical attempt to prolong the action of insulin. A new crystalline insulin has since been prepared with an action said to be comparable to the action of protamine insulin.[2] Most of the investigations described thus far have been carried out on hospital patients,[3] but Bowcock[4] has described a method for use in office practice.

Protamine insulinate is a compound formed by the addition of a buffered protamine solution, obtained from the sperm of a trout, Salmo Iridius, to ordinary insulin hydrochloride with the formation of a flocculent white precipitate which contains the insulin in combination. The supernatent fluid is inactive. The new preparation as supplied for clinical trial consists of a rubber-capped bottle containing four cc. of insulin hydrochloride of U 50 strength, and a rubber-capped ampoule containing one cc. of buffered protamine insulin. Exactly one cc. of the protamine solution is added to the insulin and five cc. of protamine insulin, U 40 strength, is the result. The preparation must be kept refrigerated, and the manufacturers advise at present that it not be used for more than two weeks after admixture. In an attempt to promote stability and to further increase efficiency, salts of calcium and zinc have been added to some of the more recent preparations.

For administration, a cool, dry, sterile syringe is used with the usual precautions. Before withdrawing the dose from the bottle, it should be agitated gently to insure a uniform mixture. Care should be taken to avoid sites of recent insulin injections; in hospital practice the nurse should chart the injection site and not depend on memory in finding a new area for injection. If regular insulin is to be injected after the protamine compound, the syringe must be cleaned or another syringe used, as the excessive protamine will combine in the syringe with the regular insulin to form more protamine insulin.

METHOD OF OBSERVATION

Most of the patients in this series were selected from a large out-patient department because control had been difficult on large doses of regular insulin. Five cases with severe infections are also included. All patients were admitted to the hospital where results could be more closely checked. Diets varied on individual patients from about 140 to 160 grams of carbohydrate a day. Urine specimens were tested for sugar seven times daily at the following times: fasting, one hour after each meal, and three hours after each meal. Results obtained on these specimens give a lead to any change of routine necessary to establish control. When urine specimens became sugar-free, blood sugar control was checked at corresponding times, and at midnight and at 4 a. m. to determine the amount of fluctuation.

Because patients had shown difficult control on regular insulin, they were abruptly switched to protamine insulin, giving the total previous daily dose one hour before breakfast. Supplementary doses of regular insulin were used for two or three days if the patient showed a marked glycosuria. Because of a post-prandial glycosuria in the mornings, which could not otherwise be controlled, some patients had to have a small dose of regular insulin before breakfast.

ILLUSTRATIVE CASES

CASE No. 1. A woman, aged 44 years, has had diabetes for four years. She had only fair control on 40 units of insulin daily, and a diet containing 150 grams of carbohydrate. Fasting blood sugar was usually above 0.15%. She was changed to 40 units of protamine insulin daily, after which all specimens became sugar free. Blood sugar for 24 hours fluctuated between 0.08% and 0.133%.

CASE No. 2. A woman, aged 38 years, was well controlled on 40 units of regular insulin daily until she suffered a fractured mandible in an accident. She was very difficult to control with insulin dosage going as high as 120 units a day. Treatment with protamine insulin with supplementary doses of regular insulin was instituted, and the patient was finally well controlled on one dose of 36 units of protamine insulin per day.

CASE No. 3. A colored girl, aged 19 years, has had diabetes for eight years. Her control

had always been very difficult on insulin dosage varying from 60 to 75 units a day. During the past year sugar free specimens had been unusual, and fasting blood sugar varied between 0.25% and 0.4%. The only complication was bilateral cataracts. On a single morning dose of 60 units of protamine insulin she had glycosuria throughout the morning, but blue tests usually for the remainder of the day. She was finally stabilized on 50 units of protamine insulin and a simultaneous dose of 20 units of regular insulin. Her highest blood sugar after this was 0.2%.

Case No. 4. A colored woman, aged 43 years, has had diabetes for three years, uncomplicated except for hypertension and arteriosclerosis. Control had been very poor on 20-20-20. She was switched to 60 units of protamine insulin as a morning dose, and after the third day no urine specimens contained sugar. Dosage had to be reduced to 40 units daily because of insulin reactions. Blood sugar on this dosage varied from 0.117% to 0.181%.

Case No. 5. A colored boy, aged 14 years, had had diabetes for two and a half years and had been in coma three times. He varied his insulin dosage and doses to suit his convenience, and had never brought in a negative specimen while ambulant. Usual dosage was about 45 units a day. Finally he was fairly well controlled on 60 units of protamine insulin daily, but would occasionally still have blood sugar as high as 0.3%.

Case No. 6. A woman, aged 52 years, had always been easily controlled on 16 units daily in two doses. On an equivalent amount of protamine insulin she had frequent mild reactions. She was reduced to a 10 unit single morning dose. Blood sugars on this 10 units daily: fasting 0.117%, 1 hour after breakfast 0.166%, 3½ hours after breakfast 0.117%, 1 hour after lunch 0.148%, 3½ hours after lunch 0.166%, midnight 0.102%, 4 A. M. 0.121%.

One patient showed poorer control on protamine insulin for eight days than on regular insulin, in spite of the fact that she received ten units more daily of the new preparation. This, however, is not a fair test, as White[5] has had a similar experience, the patient being controlled after the 21st day. One patient has died while on protamine insulin; this was a colored woman admitted to the hospital with a staphylococcic septicemia. Control of her diabetes was satisfactory until time of death.

COMMENT

The treatment of diabetes mellitus with protamine insulin presents many advantages over the old type of management. Most patients can be well controlled on one dose daily, an occasional one requiring a small simultaneous dose of regular insulin. Insulin reactions have occurred in this series frequently, and have been mild in character and slow in onset; severe insulin ractions, however, have been reported. All patients except one exhibited better control on one dose of protamine insulin than on two or three doses of the regular insulin. Certain disadvantages should also be noted, namely, the instability of the preparation, the requirement of constant refrigeration, and the need for two different kinds of insulin for some patients.

Both plain protamine insulin and the preparation containing zinc and calcium have been used in this series, but no attempt is made in this report to evaluate the relative efficiency of the different preparations. An improved crystalline insulin has been used on a few patients, but not enough data are available to warrant publication.

SUMMARY

The findings in this series of cases agree with the observations of previous investigators. Due to its slow and constant action, the management of diabetes with protamine insulin more nearly simulates the normal carbohydrate metabolism than the old method with the use of regular insulin.

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C. D. Christ, M.D., Alteroate *Orlando*
(Terms expire after A.M.A. meeting, 1936)

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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PRE-CONVENTION MEETING OF THE FLORIDA MEDICAL ASSOCIATION COMMITTEES JANUARY 17, 1937, AT JACKSONVILLE

Owing to the fact that the convention of the State Association will be held in April, it has been deemed wise to advance the time of the Pre-Convention Meeting to a date in January. The third Sunday in the month, January 17, 1937, has been tentatively selected. An expression from a majority of the members in attendance at the recent meeting in Lake City indicated that Jacksonville is the preferable location for the January meeting.

Each member of all committees are urged to begin at this time to make a definite plan to save the date of January 17th so that he may attend and take an active part in the extremely important work which will be done at that time. This pre-convention meeting is second only to the Annual Convention of the Association in importance to organized medicine.

THE NEXT ANNUAL MEETING

The next annual meeting of the Florida Medical Association will be held in St. Petersburg at the Vinoy Park Hotel, April 5, 6, and 7, 1937. While this date is a bit earlier than is customary, and earlier than it is desired, it was felt by the Executive Committee that the various phases of the situation justified the holding of the meeting at this time.

The meeting will be held at the Vinoy Park Hotel which offers facilities such as have seldom been enjoyed by the Florida Medical Association. There are ideal committee rooms; the auditorium is of ample size, and it meets every requirement for our meeting. The space for exhibits is larger and better located than at previous meetings. The hotel is extremely anxious to have this convention and will use every endeavor to make it a success from their standpoint. Incidentally, the Vinoy Park Hotel is one of the largest and finest of the tourist hotels in this State. They have made an unusually attractive rate—about one-half of their usual charge—for the convention guests. The hotel rate is further reduced by the fact that it includes the banquet ticket for those who are registered.

The Pinellas County Woman's Auxiliary, which is one of the most active in the State, has already begun active plans for the entertainment of the unusually large number of physicians' wives. There will be golf, fishing, a stag smoker, and other entertainment for the men. The banquet, in addition to having considerable entertainment, will have a dance with a special orchestra.

The highlight of the meeting will in all probability be the fact that Doctor Morris Fishbein, Editor of the Journal of the American Medical Association and of Hygeia, will be the guest speaker. It is probable that there is no speaker in organized medicine who has the oratorical ability of Dr. Fishbein. He will appear at the Tuesday morning session of the convention and will be the chief speaker at the banquet. Anyone who has heard him knows that a rare treat awaits on these occasions.

A new feature is being arranged for this convention in the nature of an open-air meeting in Williams Park on Monday evening, with an expected attendance of from ten to fifteen thousand laymen from all parts of the nation. Doctor Fishbein will be the principal speaker also at this meeting and it is believed that organized medicine will greatly benefit from this contact. It is anticipated that Doctor Fishbein's address in the park meeting will be broadcast over W-SUN or W-FLA.

The Committee on Scientific Work state that they have already been promised a number of exceptionally fine papers, and they assure us

that this major feature of the meeting is destined to be well above the average.

With the assurance of excellent papers and entertainment for both the doctors and their wives, and of the increasing necessity because of economic reasons for the assembly of the doctors of Florida, it is urged that plans be started at once to attend this meeting.

PROGRAM TO PRESERVE HEALTH

With the birth of modern medicine, the medical profession accepted the responsibility to advance the understanding of cause and prevention of infectious diseases. At times it seemed all labor would be lost for only a part of the public would accept any of our offered assistance. Prejudice was difficult to overcome. Superstition and established practices live on through the generations. In spite of these facts we can turn at this season, take stock and recognize progress that must make us feel grateful.

This organized effort of medicine to conserve and to improve the health of our fellow-men was aimed at different objectives at different periods. This was in part due to experience and in part to changing demands of the period. This whole organized effort to prevent sickness has developed a number of activities to meet an emergency or a problem of developing industry.

There is at present a problem which it is believed should have more of our effort in its solution. This problem is the multiplicity of names for simple remedies and simple food products that mystify the public and fool the profession. The public and the profession are often fooled by high-sounding names and pressure salesmanship into using simple materials in remedies or foods as something new or extraordinary, at times finding them injurious to good health.

All remedies and all combinations of food or remedies should be properly labeled as to the substances they contain. It would be in the interest of public health to unmask commercial labels. "Caveat emptor" would no longer rule the purchase of these vital articles affecting the health of the nation.

PLAN TO ATTEND
THE
PRE-CONVENTION MEETING
JACKSONVILLE
JANUARY 17, 1937

MORE ABOUT THE FLORIDA INDUSTRIAL COMMISSION AND ITS CHAIRMAN

JULIUS C. DAVIS, M.D.,
Chairman, Committee on Legislation
and Public Policy,
Quincy.

The members of the Florida Medical Association certainly owe a debt of gratitude to the Hon. Wendell C. Heaton for the efficient manner in which he has handled claims coming under the Workmen's Compensation Act. The members of this Association should really know more about the man and use every effort should the occasion arise to see that he remains at the head of the Florida Industrial Commission.

Ofttimes amid the hue and cry of various offices in our State house, we overlook a new department that is doing a big job in a big way.

This is the Florida Industrial Commission with its most able administration of the Workmen's Compensation Act. Tucked away in a cubby hole office adjoining the Senate Chamber, Wendell C. Heaton, the Chairman, and his small band of assistants handled more than 100 claims daily during the first year of the Compensation Act. This meant a total of 31,000 cases, which brought more than $1,100,000 in funeral, medical and compensation benefits to employees throughout Florida.

This million-dollar job cost Florida about $20,000, financed by a 2% tax on compensation premiums.

An excellent test of Heaton's absolute fairness, impartiality, and sound judgment in deciding these thousands of cases is shown by the fact that the circuit and supreme courts have upheld the Commission in every decision appealed.

Under the Act, an employee or employer always has the right to appeal an award of the commission if he does not think it is equitable.

In his ceaseless fight to better labor conditions and to make Florida a safer place in which to work, Heaton on October 1 established a Safety Department. This department gives and receives suggestions from employees and employers alike on how to stamp out danger in industry.

To understand how an undertaking of such magnitude can operate so successfully and with so little hullabaloo, we must know its motivating force—Heaton.

Although only 40, he probably has held more prominent labor posts and accomplished more

for the laborer than any other man in Florida. He followed the carpenter's trade for a number of years, served as president of the West Palm Beach union, district council, and later was selected as president of the Carpenter's Council.

In 1931 he was elected president of the Florida Federation of Labor and has served continually since that date. A distinct compliment to his administration is that no labor disturbance occurred during that five-year period. That deserves a hearty slap on the back when we think of the many labor disputes in practically every section of our country during the same time.

He has served as a member of the State Welfare Board, State Planning Board, State Labor Compliance Office, NRA, and Miss Perkins, Secretary of Labor, chose him as a member of her national advisory committee. He is now chairman of this group.

With such a record of service behind him, Heaton now plans to offer our Legislature a proposed labor setup which will combine about six state agencies under one head. It also will handle compensation matters and the federal security act.

Although in purely a formative stage now, Heaton, after months of work, is positive that it will be an economical and efficient step for Florida to follow such a plan.

CORRESPONDENCE

To the Editor :

JOINT MEETING OF FLORIDA STATE BOARD OF HEALTH AND FLORIDA MEDICAL ASSOCIATION.

There was held at the Blanche Hotel, in Lake City, Sunday, December 6, a joint meeting of all the members of the State Board of Health, the State Health Officer, a number of State Health Department Directors, and the officers and many committee members of the Florida Medical Association.

There was discussed in considerable detail the definite relationship necessarily existing between these two organizations. The active and intelligent support, advice, and cooperation of the Florida Medical Association was pledged to the Board of Health. In turn, members of the Board of Health and the State Health Officer assured the Florida Medical Association of their earnest desire to cooperate with and be advised by the State medical profession. The prospective increased activities of the health organization as a result of a rather generous assignment of Federal funds, in addition to increased realization as expressed in a financial way by county commissioners of the importance of public health work, renders necessary a much more serious contemplation of this problem by the members of organized medicine.

Officers and members who were present in the meeting in Lake City felt that this endeavor would in no way encroach upon the principles or functions of the Florida Medical Association. In fact, it was made quite clear by the Board members and State Health Officer that such was the case, and, further, that their activities would, in a very large measure be guided by the advice of the Florida Medical Association which, after all, is the group probably more interested than any other.

On the other hand, there was definite expression, and it is believed that this was agreed to by the majority, that it is highly essential that organized medicine take a much more active part in public health matters than it has done in the past. In the first place, there is definite benefit to be realized by the State of Florida from this cooperation. In the second place, if we do not cooperate and attempt to counsel with and guide the activities of the health organization, we are going to find that a demand for this work will be made by lay organizations such as women's clubs and civic organizations to the extent that they will necessarily be put into control and, unfortunately, organized medicine may find itself in the embarrassing position of being left out of the picture. We insist that we are more capable of giving the necessary advice, guidance, and direction than other organizations, and we must realize that it is a duty which we owe to the people of the State and, incidentallly, a duty which we owe to ourselves as a matter of self-protection.

In this connection it is earnestly requested that the physicians in the various counties give every consideration to, and endeavor to cooperate with, the plans of the State Board of Health in its advocation of the establishment of county health units and in carrying out the provisions of the Maternal and Child Health groups. If we cooperate intelligently we can be sure of wielding a very great influence. If we do not take this attitude, we can be sure that the projects will proceed without our aid with the resultant embarrassment to ourselves and decreased efficiency of operation.

Again, these county groups are asked to consider these questions very seriously before declining them, and, if possible, to accept them and offer active cooperation.

(Signed) O. O. Feaster, M.D.,
President, Florida Medical Assn.

STATE NEWS ITEMS

Dr. and Mrs. C. O. Anderson of St. Petersburg, announce the birth of a son, Roy McAlister, on November 12.

* * *

Dr. A. T. Eide of Lake Placid was elected Representative to the Legislature from Highlands County in the November election.

* * *

Dr. H. Bernard McEuen announces the removal of his offices from the Professional Building to 402-5 St. James Building, Jacksonville. Dr. McEuen limits his practice to radiology.

* * *

A son was born to Dr. and Mrs. A. R. Frederick of St. Petersburg on October 10. He has been named William Dougherty.

* * *

Doctors H. O. Brown of Tampa, Walter A. Weed of Orlando, Elliott M. Hendricks of Ft. Lauderdale and O. O. Feaster of St. Petersburg attended the meeting of the Radiological Society of North America held at Cincinnati, November 30-December 4.

* * *

Dr. Lauren McCall Sompayrac of Jacksonville, who is now in London, England, studying dermatology, is expecting to return to Jacksonville in January, 1937, and be associated with Dr. J. Lee Kirby-Smith in the practice of dermatology. Dr. Sompayrac is a graduate of the University of Florida, and the School of Medicine of the University of Pennsylvania, and had his internship at the Garfield Memorial Hospital of Washington, D. C.

* * *

Dr. Edgar Watson, associate of Dr. Herman Watson of Lakeland, has recently had a month's postgraduate study of the heart under Dr. Paul White and associates in Boston. He stayed for another month of study of fractures. Doctors Watson have recently installed an electrocardiograph in their offices.

Dr. L. M. Anderson of Lake City, past president of the Florida Medical Association, celebrated his seventy-fifth birthday on October 14. The members of the Columbia County Medical Society, of which he has been president for many terms, surprised him with a delightful dinner in the private dining room of the Blanche Hotel, Lake City. Among out-of-town guests were Dr. Thomas S. Anderson of Live Oak, older brother of "Dr. Lon"; Dr. Shaler Richardson of Jacksonville, secretary of the Florida Medical Association; Drs. William Ross of Jacksonville, Henry E. Palmer of Tallahassee, and Julius C. Davis of Quincy, past presidents of the Association. Telegrams and letters of congratulation received from every living past president of the State Association were read while numerous words of praise and esteem were spoken by those present. So overcome with emotion that he could hardly rise to his feet, Doctor Anderson responded, simply saying: "Boys, this is the happiest event of my life and I thank you,"—words typical of his rugged honesty and simplicity of character.

* * *

Dr. J. Ralph Vallotton, former institution physician at the Florida State Prison, has returned from Europe where he took postgraduate work in Vienna. He has opened offices at the Hamilton Hotel in Daytona Beach.

* * *

Dr. Harry S. Howell, formerly of Chattahoochee, has moved to Lake City where he has opened offices in the Blanche Hotel Annex.

* * *

Dr. L. W. Glatzau and Mrs. Winnifred McDonald of Daytona Beach were married on November 12 at 6:30 p. m. in a simple but impressive ceremony. They left immediately after the service for Washington and Baltimore.

* * *

Dr. A. G. Holmes of Miami Beach has moved to Daytona Beach where his address is 210 S. Grandview Avenue.

* * *

The Deederer Health Clinic has been opened by Dr. Carleton Deederer at 139 S. E. Third St., Miami.

* * *

Dr. Herbert W. Bearce, formerly of Daytona Beach, has moved to Port Orange.

The fall meeting of the Florida Radiological Society was held October 31-November 1, 1936, at the Good Samaritan Hospital, West Palm Beach. Dr. Frederick K. Herpel, Director of the Department of Roentgenology, and a past-president of the society, acted as host for this meeting.

Inspection by the group of the newly-installed, oil-cooled, shock-proof, high voltage therapy equipment preceded the meeting.

Sessions were devoted to roentgen diagnosis, economic and business problems, and roentgen and radium therapy. Informal discussions dominated the sessions as in previous meetings. Reports from the recent postgraduate therapy course at the Michael Reese Hospital, Chicago, Illinois, and from the annual meeting of The American Roentgen Ray Society in Cleveland, were made by members who attended these sessions.

The following members, specializing in roentgenology and radiology, were present:

Dr. Orion O. Feaster, St. Petersburg, President of the Florida Medical Association.

Dr. Harold O. Brown, Tampa, Secretary.

Dr. Joshua C. Dickinson, Tampa.

Dr. Elliott M. Hendricks, Fort Lauderdale.

Dr. Frederick K. Herpel, West Palm Beach.

Dr. John Herring, St. Petersburg.

Dr. Joseph H. Lucinian, Miami.

Dr. Frazier J. Payton, Miami Beach, President.

Dr. J. A. Pines, Orlando.

Dr. W. McL. Shaw, Jacksonville.

* * *

Dr. David R. Murphey, Jr., of Tampa addressed the Surgical Section of the Southern Medical Association, November 19, in Baltimore. His subject was "Carcinoma of the Breast."

* * *

Dr. and Mrs. J. R. Boulware, Jr., of Lakeland announce the birth of a son, Robert Asher, November 12 at the Morrell Memorial Hospital.

* * *

Dr. J. H. Chiles of Orlando has moved to Holopaw.

* * *

Dr. W. T. Simpson of Winter Haven announces the association with him in practice of Dr. L. L. Lancaster of Bartow. Doctors Simpson and Lancaster have offices in the Taylor Building, Winter Haven.

Dr. Robert B. McIver of Jacksonville presented one of the four papers which featured the meeting of the Georgia Urological Association, held at the Dempsey Hotel, Macon, on October 29. Doctor McIver's subject was "Surgery of the Ureter", which he illustrated with lantern slides and motion pictures. On the day preceding the meeting, the speakers were entertained by Atlanta urologists at clinics in Atlanta, a luncheon at the Georgia Baptist Hospital and a dinner at the Atlanta Athletic Club, attended by 50 doctors.

* * *

Orlando has been selected as the site of the Fifth Annual Graduate Short Course for Doctors of Medicine to be held in June, 1937. The change from Gainesville was made by the committee after correspondence with representative physicians in all parts of the state, the majority of whom expressed themselves in favor of the idea.

Because Orlando is more centrally located than Gainesville the committee feels that it will be more convenient for those physicians who wish to attend the Course. The change to Orlando is not intended to be permanent. The success of the coming Short Course will determine where the courses will be held in the future.

There will be no alteration of the relationship of the Florida Medical Association and the University of Florida in presenting the Short Course.

* * *

Dr. W. G. Miles has been employed as a psychiatrist at the Florida State Hospital. Doctor Miles was formerly connected with the State Hospital, having served on its Staff from July 4, 1927, to August 30, 1933.

* * *

Dr. M. P. Travers announces the removal of his offices to the Lincoln Medical Bldg., Miami Beach, and the Ingraham Building, Miami, with the restriction of his practice to traumatic surgery.

* * *

Dr. Charles E. Boynton, Jr., of West Palm Beach announces the removal of his offices to 1923 Comeau Building. His practice is limited to pediatrics.

* * *

Dr. Edmund H. Teeter of Jacksonville was recently elected president of the local Exchange Club. He has been a member of the club's board of control and active in its affairs for a number of years.

The Riverside Hospital at Jacksonville held its fourth annual staff meeting on Monday, November 30, at which time the following papers were read:

"Observations on the Handling of Thyroid Problems", Edward Jelks.

"Some Phases of the Diagnosis and Management of Lesions of the Large Bowel, Including the Rectum", Harry A. Peyton.

Following the scientific session the sixty guests were entertained with an oyster roast at Dr. T. Z. Cason's place on the southside of the St. Johns River. The occasion was most enjoyable as evidenced by the enthusiasm and good fellowship of those present.

Out-of-town guests were: Drs. J. L. Summerlin, Fred Mathers, G. C. Tillman, Chester F. Ahmann, and W. C. Thomas, Gainesville; R. B. Harkness, T. H. Bates, and H. S. Howell, Lake City; T. H. Wallis, C. W. Mimms, and Eugene G. Peek, Ocala; J. E. Taylor, T. F. Hahn, and Hugh West, DeLand; T. H. Davis, Green Cove Springs; J. M. Price, Live Oak; Henry E. Palmer, Tallahassee, and E. W. Ford, Crescent City.

* * *

Dr. L. Y. Dyrenforth of Jacksonville attended the Cancer Institute held at Madison, Wisconsin, in September.

* * *

Dr. C. C. Bottari of Tampa announces the opening of offices at 1202-1204 First National Bank Building. His practice is limited to dermatology and syphilology.

* * *

The Florida Medical Association was well represented at the meeting of the Southern Medical Association, which was held November 17-20 at Baltimore, Maryland. The following members of our Association registered at this meeting:

Anderson, L. M. Lake City
Adamson, W. P. Tampa
Andrews, C. A. Tampa
Baltzell, N. A. Marianna
Blake, L. W. Bradenton
Boling, John R. Tampa
Borland, James L. Jacksonville
Bowen, Frederick Hardy Jacksonville
Brown, Alan Jacksonville
Chappell, Frank V. Marianna
Cleveland, Jack Q. Miami
Collins, C. J. Orlando
Dailey, I. A. Micanopy
Daves, Frank E. Chattahoochee
Dean, R. H., Jr. Jacksonville
Dickinson, J. C. Tampa
Doern, William G. Daytona Beach
Estes, Jas. L. Tampa
Folsom, S. A. Orlando
Fort, Frank Leslie Jacksonville
French, Elmo D. Miami
Gammon, Julian E. Jacksonville
Glatzau, Lewis W. Daytona Beach
Grimes, D. H. South Miami
Gwathmey, G. Tayloe, Jr. Orlando
Harkness, R. B. Lake City
Harris, R. M. Miami
Holloway, Luther W. Jacksonville
Jefferson, Rollins Tampa
Johnston, J. K. Tallahassee
Jones, Walter C. Miami
Kirby-Smith, J. L. Jacksonville
Knowlton, R. H. St. Petersburg
Lefholz, Rothwell Miami
Lyerly, J. G. Jacksonville
Manning, William S. Jacksonville
Marr, N. M. St. Petersburg
Merchant, H. M. Gainesville
Miller, R. L. Graceville
Milton, J. D. Miami
Moor, F. C. Tallahassee
Morris, Kenneth A. Jacksonville
Murphey, David R., Jr. Tampa
McEachern, J. R. Tampa
McIver, Robert Boyd Jacksonville
Netto, Jos. Lloyd West Palm Beach
Nobles, Robt. G. Pensacola
Norris, S. R. Jacksonville
Oetjen, Geo. Frederick Jacksonville
Orr, Louis Orlando
Panettiere, Cayetano Miami Beach
Payton, Frazier J. Miami Beach
Peyton, Harry A. Jacksonville
Pickett, Wm. H. Pensacola
Quillian, Warren Coral Gobles
Roberts, Earl H. Jacksonville Beach
Robertson, J. C. Chattahoochee
Roche, C. F. Miami Beach
Rollins, C. D. Jacksonville
Royce, Clayton E. Jacksonville
Rudolph, C. C. St. Petersburg
Shaw, E. Clay Miami
Simpson, J. Knox Jacksonville
Smith, Burdette Tampa
Smith, D. T. Gainesville
Spicer, Robert T. Miami
Tallman, M. H. Miami
Teeter, Edmund H. Jacksonville
Thames, Rufus Milton
Thomas, W. C. Gainesville
Vinson, J. C. Tampa
Walker, Harrison A. Miami Beach
Walters, Arthur L. Miami Beach
Webb, Carl C. Pensacola
Whitaker, C. D. Marianna
Wilson, C. B. Sarasota
Young, W. C. Chiefland

Dr. A. Boynton Wilber of Palm Beach is moving from 203 Seaview Avenue to 170 Seaview Avenue.

* * *

At its annual meeting recently, the St. Francis Hospital Staff, Miami Beach, elected the following officers for the coming year:

President—Nelson M. Black.
Vice-President—D. Ward White.
Secretary—Paul K. Jenkins.

* * *

Dr. R. H. Randall, who practices during the summer at White Sulphur Springs, W. Va., has returned to Boca Raton where his address is: Boca Raton Club.

* * *

Dr. and Mrs. M. A. Nickle and daughter, Margaret, have returned from a three months tour of Europe. Doctor Nickle spent three weeks in the eye and ear hospitals in London.

JOHN ROBERT CASON

Dr. John Robert Cason was born in Pine Bluff, Arkansas, April 13th, 1881. His father was John R. Cason and his mother Rebecca Ingram Cason, both now deceased. Dr. Cason received his premedical work at Hendricks College, Conway, Arkansas, and graduated from the Medical School of the University of Arkansas in 1903. After his internship at St. Luke's Hospital in Little Rock, Arkansas, he came to Florida in 1905 and located at Delray Beach, where he resided until his death August 29th, 1936.

During the World War he served overseas with the medical corps of the Red Cross. He was a 32nd degree Mason and during his lifetime was active in civic affairs.

The United States Civil Service Commission announces open competitive examinations for the following positions: Senior Medical Officer—Female (Psychiatry), $4,600 a year; Junior Medical Officer (Interne), $2,000 a year; Junior Medical Officer (Psychiatric Resident), $2,000 a year. Applications must be on file with the United States Civil Service Commission at Washington, D. C., not later than January 4. Application forms may be obtained from the Secretary, Board of United States Civil Service Examiners, at any first-class post office or from the U. S. Civil Service Commission, Washington, D. C.

The American Association for the Study of Goiter again offers the Van Meter Prize Award of $300.00 and two honorable mentions for the best essays submitted concerning experimental and clinical investigations relative to the thyroid gland. This award will be made at the discretion of the Society at its next annual meeting to be held in Detroit, Michigan, June 14, 15, and 16.

The competing manuscripts, which should not exceed 3,000 words in length, must be presented in English and a typewritten double spaced copy sent to the Corresponding Secretary, Dr. W. Blair Mosser, 133 Biddle Street, Kane, Pennsylvania, not later than April 1, 1937. Manuscripts received after this date will be held for competition the following year or returned at the author's request.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The meeting of the Dade County Medical Society held December 4 was, in main, a business meeting, being devoted to the second reading of many proposed changes to the Constitution and By-laws of the organization and to the election of officers. As this Journal goes to press, the result of the election has not been learned.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Simmons Hotel, Wauchula, November 10th, with Dr. G. S. McKnight, president, in the chair. The scientific program consisted of a paper by Dr. W. Wardlaw Jones of Dade City on "Some Observations of Early Pregnancy with Special Reference to Abdominal Pains," and an article by Dr. G. H. McSwain of Arcadia on "Treatment of Burns."

DUVAL COUNTY MEDICAL SOCIETY

The annual election of officers was held by the Duval County Medical Society on December 1, at the Mayflower Hotel, Jacksonville. The following doctors were chosen to head the organization during the coming year:

President—Kenneth A. Morris.
President-elect—J. Lunsford Boone.
Vice-President—George Richardson.
Secretary—George W. Croft.
Treasurer—J. W. Hayes.

ERRATA

In last month's Journal, the Duval County Medical Society and its officers were complimented for having 100% membership dues paid for 1936. Through an oversight, the vice-president's name was omitted. The vice-president of the Society for 1936 was Dr. Charles B. Mabry. Our apologies to Dr. Mabry.

HILLSBOROUGH COUNTY MEDICAL SOCIETY

On December 1, the Hillsborough County Medical Society held its annual election of officers, which resulted as follows:

President—George L. Cook, Tampa.

Vice-President—J. W. Alsobrook, Plant City.

Sec'y-Treas.—James S. Grable, Tampa.

Censor—W. P. Adamson, Tampa.

Delegates elected to represent the Society at the 1937 meeting of the Florida Medical Association were: W. M. Rowlett, William C. Blake and H. Mason Smith.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held a meeting at the Shrine Club, December 4 at 6:30. Dr. Gideon Timberlake presented an article on "Pathology, Symptomatology and Diagnosis of Diseases of the Prostate," and Dr. A. J. Logie of the State Board of Health outlined plans for an anti-tuberculosis program.

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY

THE ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY BECOMES THE EIGHTEENTH SOCIETY TO REPORT 100% OF MEMBERSHIP DUES PAID FOR 1936. THE 1936 OFFICERS OF THE SOCIETY UNDER WHOSE LEADERSHIP THIS ACHIEVEMENT WAS ATTAINED WERE: M. D. COUNCIL, FT. PIERCE, PRESIDENT, AND G. C. HARDIE, FORT PIERCE, SECRETARY-TREASURER.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

State Editor

MRS. J. RALSTON WELLS,

P. O. Box 9,

Daytona Beach.

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MRS. S. M. COPELAND, President-elect *Jacksonville*
MRS. GORDON IRA, Vice-President *Jacksonville*
MRS. ROBERT D. FERGUSON, Secretary-Treasurer *Ocala*
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Perhaps it is because she is a friend of mine, a clubwoman as well as a doctor's wife, and because I know the quality of her mind and the value of her work, that any message from our first Vice-President of the Auxiliary, A. M. A., Mrs. David Long of Missouri, carries a special appeal. However that may be, I want you to judge for yourself and so I am bringing you this month a few paragraphs from her official message as it appears in the Auxiliary News-Letter. Remember as you read that any auxiliary or member may subscribe to this News-Letter, and that this is only a sample of what it brings.

"The question is often asked 'How can we interest more Doctors' wives in our organization?' And my answer is: Don't spend too much time trying to sell an idea to an adult. The majority of people have fixed ideas by the time they are 25 or 30. It does not take numbers of women to make a successful organization. I know one organization of ten women with about four of them active and yet they carry through the full national Program and sponsor an Essay Contest each year besides. It is not quantity but quality of personnel that makes any organization successful.

"The leaders in the state and national Medical Auxiliary must first be enthusiastic themselves before they can hope to interest others. They must sincerely believe in the aims and purpose of the Auxiliary. Sincerity is the basis of all good work. Enthusiasm and sincerity of purpose can only come through knowledge of the history and purpose and program of the organization. So, as the first step, study. Try to arrange some time on each Auxiliary Program for a presentation of the work of the Auxiliary itself. This is found in the Handbook, the News-Letter, and the Bulletin.

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OBSTETRICS—Informal Course; Intensive Two Weeks Course storting Februory 1, 1937.

FRACTURES AND TRAUMATIC SURGERY—Informal Procticol Course; Intensive Ten-Doy Course storting Februory 15, 1937.

EAR, NOSE AND THROAT—Informol Course; Personol Courses; Intensive Two Weeks Course starting April, 5, 1937.

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"Second, study your own particular field. Ask your Advisory Council what is the thing most needed in your state or county and just what they would like for you to do. Never forget that we are auxiliary and our only purpose for organization is to serve the profession to which our husbands belong. Keep in mind also, that our national Auxiliary has adopted certain policies and that if we work together as a national unit we can achieve more for the profession in a larger sense than by concentrating all our strength on local activities.

"And third, may I add that I am not one of those who think one can serve only through activity. 'They also serve who only stand and wait.' In the past twenty years the activity of women has increased by leaps and bounds and it is my opinion that women can lose their greatest force and strength by over-activity. The world is a very busy place today and everyone is in a hurry to keep up with themselves. To learn the art of quietude is a refreshing thing to do. The greatest strength comes from the quiet hours. Husbands and children need quiet homes in which to come for shelter from the embroglio of the world activity. The same can be true of our organization work. To demonstrate through quiet support of the aims of the American Medical Association that the purpose of our existence is not so much to be aggressive as it is to be supportive.

"By the dignity of our individual lives as they, in turn permeate the organization in which we work together for the good of the profession we can demonstrate the role that we play. Last May at the close of the wonderful meeting in Kansas City, I had a conversation with one of the outstanding newspaper women in the United States. She has served a large metropolitan newspaper for many years and about every six years the newspaper sends her abroad for several months for study to broaden her outlook and increase her usefulness. She complimented the Program of the American Medical Association and then said, 'they are the most distinguished lay group in America.' Such a compliment from a woman of wide experience, education and travel is not to be taken lightly. If this is true of the group to which we are auxiliary, then we, the members of the auxiliary, should see that we, too, shall emulate dignity and prestige of this organization in all our work.

"And so, is it any wonder that at last through

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the long ages of work and striving the doctor is set aside as one who walks on the high road? What should be the reaction of the doctor's wife to this elevated status that has been given her husband? Does she think of it as something to satisfy ambition for social prestige as expressed in a too full social calendar and with values based on the snobbery of things that money can buy, or does this classification make her justly humble with the weight of her responsibility? Men cannot rise to their highest and best capabilities unless their wives, too, possess the idealism of their profession. Yes, the wives of doctors need training also—training in character, training in intellectual poise and training to live this role of doctor's wife."

* * *

PINELLAS COUNTY AUXILIARY

The Auxiliary to the Pinellas County Medical Society met for lunch at the St. Petersburg Yacht Club, October 27th. The tables were artistically decorated in seasonal Hallowe'en style. The meeting following was presided over by the president, Mrs. Franklin W. Roush. The charge to the Auxiliary from the President of the Florida Medical Association was read and discussion of methods of carrying it out were discussed. Dr. John A. Herring was appointed by Dr. N. M. Marr, President of the Pinellas County Medical Society to serve as advisor to the Auxiliary.

* * *

ORANGE COUNTY AUXILIARY

The Auxiliary to the Orange County Medical Society held its first fall meeting on Oct. 28 at the Orange Court Hotel and immediately pledged itself to furnish a unit for the Tubercular Unit which is to be added to the Orange County Farm. A unit consists of bed complete with bedside table and everything in the way of supplies for the comfort of the patient. The Auxiliary is the first organization to make such a pledge. A card party was held on Nov. 6 to begin the raising of funds for this project.

This Auxiliary is a member of the Needlework Guild and their ingathering was held at this meeting. Some of the members have been collecting flour sacks from the stores and bakeries and having them made into sheets at the PWA sewing room to be turned over to the county nurse for her work.

With such a spirit of good fellowship and cooperation manifested, the members agree that a Woman's Auxiliary is well worth while.

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DADE COUNTY AUXILIARY

The Woman's Auxiliary to the Dade County Medical Society met Monday, Nov. 9th, at the residence of Mrs. Arthur Walters, Miami Beach. The meeting was called to order by the president, Mrs. E. J. Hall. The reports were given for the past year and after all business was concluded, Mrs. Hall introduced the new president, Mrs. William J. Barge, who introduced her officers and chairmen. The Auxiliary pledged to carry on Tuberculosis work in cooperation with the Dade County Tuberculosis Association. They contributed from the treasury the amount of twenty or twenty-five dollars to purchase bed lamps for the patients in the Jackson Memorial Tuberculosis pavilion. Mrs. Arthur Walters was named as delegate to the Southern Medical Convention to be held in Baltimore, Nov. 17th.

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The Borden Digest

SUMMARY OF OCTOBER ISSUE

Recent investigations showing that fresh milk, properly handled, is a better source of cevitamic acid (vitamin C) than previously supposed are discussed in the editorial which is the basis of Abstract No. 105. It is pointed out, however, in a second editorial, summarized in Abstract No. 106, that milk should not be relied upon as the sole source of this antiscorbutic factor even though it may be a significant source of it.

A formula of condensed milk and rice gruel is recommended for safe, simplified infant feeding, in the article described in Abstract No. 107.

The advantages of evaporated milk as a well-tolerated, generally non-allergic milk for infant



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feeding are brought out in Abstract No. 108, and the high potency of vitamin A in irradiated evaporated milk is reported in Abstract No. 109.

Loss of weight in the new born is best prevented by means of mixtures of Beta Lactose, according to the clinical data set forth in Abstract No. 110. The value of Beta Lactose as a carbohydrate is mentioned in Abstract No. 108.

Pasteurization of milk as a necessary factor of safety for clean milk is advocated in the article reviewed in Abstract No. 111. The high nutritive value of pasteurized milk is indicated in Abstract No. 117.

The value of malted milk in the treatment of anorexia is brought out in Abstract No. 112.

Adequate diets for school children are described in Abstracts Nos. 113 and 114. When school children in England were given supplementary meals of milk and a sandwich, general improvements in health were noted.

The advantages of certified milk to the medical profession are outlined in the editorial noted in Abstract No. 115.

The epidemiology and clinical aspects of undulant fever are ably reviewed in Abstract No. 116.

What Every Woman Doesn't Know—How To Give Cod Liver Oil

Some authorities recommend that cod liver oil be given in the morning and at bedtime when the stomach is empty, while others prefer to give it after meals in order not to retard gastric secretion. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. It is most important that the mother administer the oil in a matter-of-fact manner, without apology or expression of sympathy.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silverplated spoon (particularly if the plating is worn), a glass spoon has an advantage.

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★ *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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WHAT'S THIS? Our old friend Santa in trouble?

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You've often heard people say, "I must go on a diet". . . or . . ."I must go in for some strenuous exercise and work this fat off." But either course may be dangerous. Unwise dieting frequently substitutes, for the evil of obesity, the evil of undernourishment. Strenuous exercise obviously adds to the burden on an already overburdened heart.

There is only one sane thing for any overweight person to do. That is to see his doctor. Your doctor can determine whether obesity is caused by some fundamental physical disorder—such as glandular derangements—or whether it is the result of unwise eating combined with insufficient exercise.

Diet is a form of treatment; and it should *never* be prescribed by anyone but a physician. The doctor's knowledge is necessary in determining what foods, and how much, may be eaten —what diet will be safe and pleasant, yet effective, in removing unneeded, unsightly fat.

If *you* are overweight, or in doubt about what weight you should maintain, do something about it. But don't let well-meaning friends, or the fellow you met while on vacation, prescribe for you. See your doctor.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	23	85%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			11	92%
Brevard	I. F. Bean, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	4	50%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	24	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	10	100%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg., Miami	1st Friday 8:30 P.M.	Rod and Reel Club Hibiscus Island	209	99%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	16	76%
Duval	Kenneth A. Morris, M.D., 237 W. Duval St. Jacksonville	George W. Croft, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	151	100%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	39	93%
Hillsborough	George L. Cook, M.D., 443 W. Lafayette Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	117	99%
Jackson	C. D. Whitaker, M.D., Dekle Bldg. Marianna	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	11	73%
Lake	R. H. Williams, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis	16	100%
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	34	97%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
Manatee	S. G. Hollingsworth, M.D 451 12th. St. Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	11	100%
Marion	J. N. Moore M.D., 210-12 Professional Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12.30 P.M.	Marion Hotel Ocala	22	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	4	100%
Orange	William E. Sinclair, M.D. Clinic Bldg Orlando	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies	56	100%
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	52	93%
Pasco-Hernando-Citrus	R. D. Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M	Varies	11	85%
Pinellas	N. M. Marr, M.D 812 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D. 1005 Equitable Bldg. St Petersburg	1st. and 3rd. Friday 6:30 P.M.	Shrine Club St. Petersburg	81	100%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2od Wednesday in Feb. April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	52	92%
Putnam	Allen P. Gurganious, M.D. Palatka	A. E. Drexel, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Johns	Herbert E. White, M.D., 401 First Natl. Bank Bldg St Augustine	R. D. Harris M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	10	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies	13	100%
Sarasota	Arthur O. Morton, M.D., Commercial Court Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	18	100%
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	12	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell M.D., Box 237 Coleman	2nd Tuesday	Varies	4	100%
Taylor	J. C. Ellis, M.D., Perry	J. L. Weeks, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	5	83%
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Chowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies	37	95%
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M	Varies	6	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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VOLUME XXIII
NO. 7

Jacksonville, Florida, January, 1937

Yearly Subscription, $3.00
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FOR many centuries,—and apparently down to the present time, even in this country—ricketic children have been passed through a cleft ash tree to cure them of their rickets, and thenceforth a sympathetic relationship was supposed to exist between them and the tree.

Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.

*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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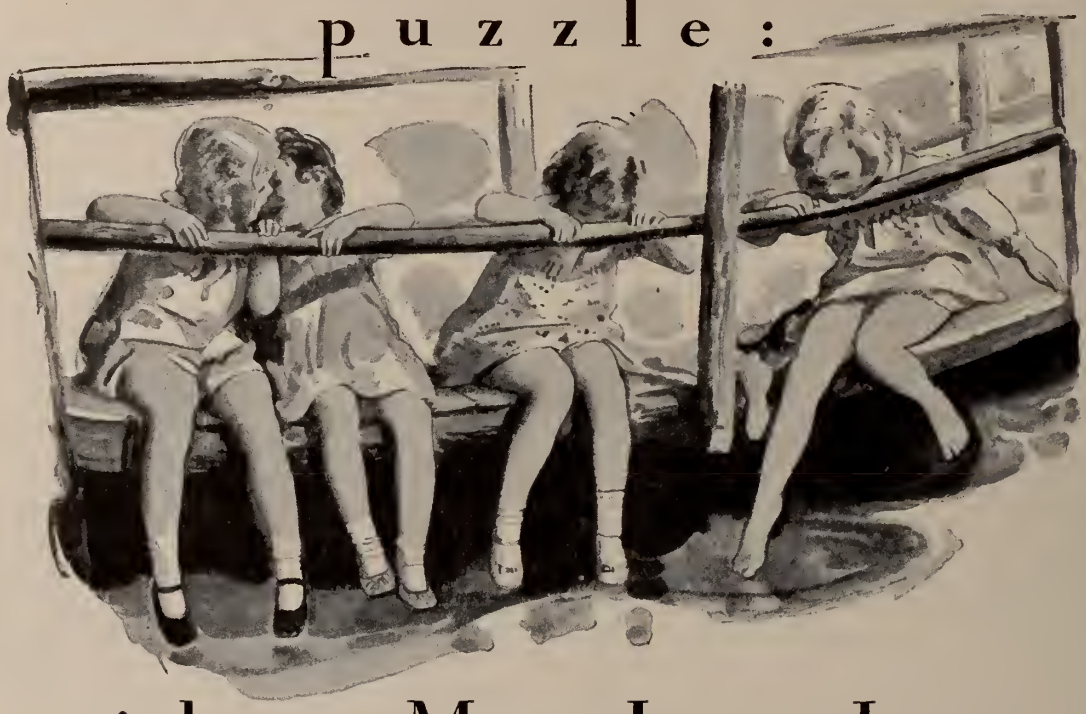
Like other specifics for other diseases, larger dosage may be required for extreme cases. It is safe to say that when used in the indicated dosage, Mead's Oleum Percomorphum is a specific in almost all cases of rickets, regardless of degree and duration. Mead's Oleum Percomorphum because of its high vitamins A and D content is also useful in deficiency conditions such as tetany, osteomalacia and xerophthalmia.

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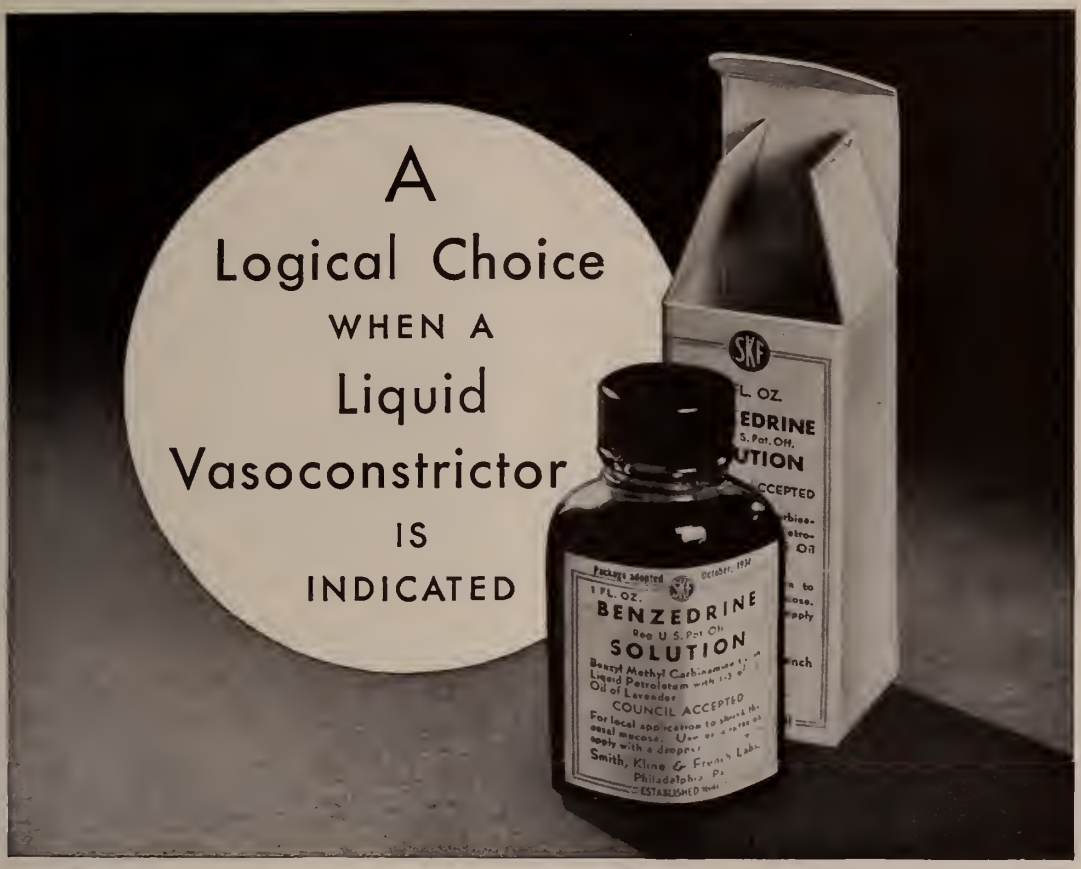
The apparent increase in diabetes in recent years has been attributed to the modern manner of living, increased sugar consumption, overeating and lack of muscular exercise. With proper management the great majority of these patients can be kept well-nourished, sugar-free and at work.

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Scarano: Med. Record: Dec. 5, 1934

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Giordano: Penna. Med. Jour.: Oct., 1935

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CONSERVATION OF ESSENTIAL ELEMENTS IN PROTECTIVE FOODS

I. MINERALS

● Considerable differences may exist between the mineral contents of foods from both the qualitative and quantitative standpoints. In fact, variation in mineral content has been noted even in the same plant variety; such variations being dependent, among other factors, upon soil or climatic conditions (1).

A striking example of the influence of one of these factors is the relative richness in iodine of field crops raised in certain coastal regions of this country where the soil is also high in iodine.

From the point of view of those concerned with human nutrition, interest in the mineral content of the food supply is usually centered around calcium, iron and iodine; since it is generally agreed that of all the essential minerals, these are the ones most apt to be inadequately supplied by the average varied diet. Conservation of these minerals in foods is, therefore, a matter of considerable practical interest.

Unlike the vitamins, minerals are not lost during storage of fruits and vegetables. However, solution losses during cooking may be severe, due to the fact that most minerals, as they occur in the plant, are soluble, or at least are extractable, by the water in which they are cooked. For example, cabbage cooked by the usual home method has been shown to lose from 21 to 72 per cent of its calcium (2).

As exemplified by these studies, solution losses of minerals in leafy vegetables are usually high. Losses in vegetables as a class are not, however, so excessive, as indicated by an average reported loss of 19.5 per cent of the calcium in seven common vegetables (3).

The average decrease during cooking in the ash content of five common vegetables has been found to approximate 37 per cent (4).

While the extent of mineral loss during ordinary home cooking methods will vary with the particular element under consideration as well as the food in which it is contained, sufficient evidence is at hand to indicate that such losses may be considerable. It is further apparent that discarding the cooking water—the usual home practice—entails a loss of valuable, essential mineral components of food.

Modern practice in commercial canning goes far in preventing these solution losses of minerals. Canned foods are cooked by the heat process accorded them while still contained within the hermetically sealed can. A minimum of water is used which also remains within the can, conserving for the consumer's use those extractable essential mineral elements which may be lost to the cooking water during home preparation of market varieties of foods.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1936 J. Nutrition 11, 55.
(2) 1936 J. Home Ecoo. 28, 18. 1925 Ibid, 17, 265
(3) 1935 J. Home Econ. 27, 376
(4) 1917 Amer. J. Dis. Chila, 14, 34

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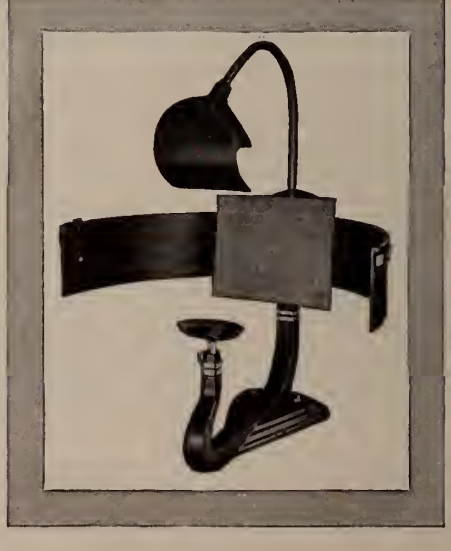
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXIII Jacksonville, Florida, January, 1937 Number 7

MANAGEMENT OF PEPTIC ULCER*

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The management of peptic ulcer and its complications is a many-sided problem. To be successful it must deal largely with the probable cause, or causes, of each specific ulcer. It must be predicated upon a working knowledge of the physiology of the affected part, or parts.

Cause and Mechanism of Ulcer Production. The cause of peptic ulcer is still uncertain. The generally accepted mechanism of peptic ulcer production is primarily a digestion of enfeebled local areas of the mucous membranes of the stomach and duodenum, presumably by the acid gastric secretions, some authorities flatly stating, "No acid, no ulcer". Behind this simple-sounding mechanism is grouped a legion of theories as to why a local area of mucosa should be digested. A few of the most tenable theories as to predisposing and exciting factors are: ulcer diathesis, heredity, mental and emotional states, allergy, faulty food habits, character of attachment of mucosa in the ulcer area, hyperacidity, local arterial embolism, chemical and metabolic toxins, nerve lesions, absence of anti-pepsin, remote foci of infection and association with remote visceral disease, which will be shown to result in trauma.

It is probable that any of the above causative factors either alone or combined may directly or indirectly cause ulcer. Of all the presumed exciting causes there is probably the most conclusive evidence behind the theory of infection plus trauma as causative factors. Rosenow[1] produced acute ulcers in animals by the injection of bacteria obtained from human ulcers, teeth, tonsils, etc. This, and subsequent experimental work, as well as controlled clinical observations, have definitely established the importance of remote infection as a causative factor in ulcer production.

Trauma Supplied by Remote Visceral Disease. You have repeatedly seen peptic ulcer associated with chronic appendicitis or gall-bladder disease which healed with the removal of the diseased organ, frequently regardless of subsequent treatment. Why should the removal of the diseased appendix or gall-bladder almost spontaneously cure peptic ulcer? It is readily conceivable that these organs may act as remote sources of infection, yet there is another perhaps more reasonable explanation for this association.

It has been shown by the author[2] that excessive stimulation of sensory nerves of some of the abdominal viscera at least, causes reflex disturbances of the gastric musculature. Normally, with the first taste of food, there is a well-marked relaxation of the muscular walls of the stomach with or without inhibition of peristalsis, thereby increasing the capacity of the stomach. In the presence of abdominal visceral disease, such as appendicitis, gall-bladder disease, ureteral stricture, urethral stricture, etc., this relaxation does not occur. Instead, there is a very marked and usually immediate increase in the muscular activity consisting either of deep contraction waves, a marked increase in tone, or both. These may be very violent and sustained for one to two hours after eating and may be so extensive as to completely obliterate the lumen of the stomach, supplying sufficient trauma to squeeze the mucous membranes and their blood vessels to the point of marked interference with circulation in this local area. This probably results in a well-marked sometimes prolonged local anemia, or ischemia, lowering the vitality and resistance of the mucosa, inviting infection, inflammation and digestion, with ulcer formation. Such reflex stimuli may continue to act as a source of continued spasm and trauma in the ulcer area, and despite the removal of the original source of infection the ulcer will remain either constantly or recurrently until the exciting visceral irritations have been removed.

It is not assumed that this is the mechanism of production of all peptic ulcers. Actual tracings of the muscular reaction of the duodenum in association with remote abdominal visceral disease have not been made but there is sufficient clinical and roentgenologic evidence to justify the assumption that spasm occurs in the duode-

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the S.S. "Florida", April 27, 28 and 29, 1936.

num as well as in the gastric musculature. Experience has shown that this combination of infection plus trauma from visceral irritation is frequent enough to justify the following postulate in ulcer management: Do not rest with the diagnosis of peptic ulcer but always painstakingly check over the entire body for sources of infection and for visceral disease or dysfunction which may be acting as an exciting cause.

Active treatment of the peptic ulcer itself should be made as simple as possible. Complicated routines are confusing and discouraging. Make your instructions explicit and your restrictions few but absolute. A simple routine has been developed which has been successful in uncomplicated peptic ulcer. This routine aims at three main objectives:

I. REST.
II. NEUTRALIZATION OF ACID PEPSIN.
III. REGULATION OF HABITS.

I. *Rest. Bodily and Mental.* Bodily and mental activity increases metabolism. Increased metabolism demands increased food ingestion, digestion and assimilation, resulting in increased digestive effort. Obviously, as much bodily and mental rest as practicable is necessary. Ideally, the ulcer patient should be kept in bed, at least during the early weeks of treatment. This is usually economically impossible, therefore ambulatory treatment must be substituted. Fortunately, in most cases, this is quite practical and satisfactory.

Digestive Rest. As near an approach as possible to complete physiologic rest of the peptic area is desirable. It is necessary to recall here that digestive functions are both muscular and secretory. It has been shown that the ingestion of carbohydrates and fats decreases the gastric motility and secretion of acid pepsin, therefore diet should consist chiefly of carbohydrates and fats in their most assimilable form. It has been found that feedings of small quantities of food at frequent intervals requires less digestive effort and has a very satisfactory neutralizing effect upon the acid pepsin secretion.

Digestive rest may be further amplified by the use of gastric lavage. It is routinely used in refractory ulcers. Lavage with hot (110 degrees Fahrenheit) tap water, or dilute bicarbonate solution, before retiring, will usually insure relaxation of the gastric musculature and digestive rest throughout the night. In some instances where secretion is excessive it is necessary to resort to interrupted siphonage.

II. *Neutralization of Acid Pepsin.* Frequent small feedings of finely divided, easily assimilable foods frequently will adequately neutralize the acid pepsin and prevent further irritation or digestion at the site of ulcer. It has become customary to place ulcer patients on a four to six-ounce feeding every two hours with three larger feedings at the regular meal times. The two-hour feedings usually consist of equal parts of cream and milk or some carbohydrate such as cream of wheat, rice or potato. The three larger feedings are selected by the patients from the list of permitted foods furnished them.

Medicinal Neutralization. Powder, in bulk consisting of equal parts of heavy magnesium oxide, bismuth subnitrate and calcium carbonate, together with one-quarter part of *colloidal* kaolin (Crookes) is prescribed. One-half level teaspoonful of this powder is given one hour before and after the three larger meals. This bulk powder has the advantage of being less expensive and being relatively insoluble obviates the likelihood of alkalosis with its associated spasm of smooth muscle. This powder in conjunction with two-hour feedings has been shown clinically to effectively control the acid secretions and prevent further digestion at the ulcer site.

Certain drugs and substances are available which are designed to have specific action upon the ulcer. Histidine monohydrochloride is the outstanding one at present. Experience with this drug has apparently been very satisfactory in controlling symptoms but what its ultimate value will be in the control or cure of peptic ulcer, the future must determine.

III. *Regulation of Habits.* This plays a most important role in successful ulcer management. Proper elimination from the colon usually occurs with the bland, low residue, non-putrefactive ulcer diet. *Alcohol:* Alcohol in any form must of course be completely restricted. *Tobacco:* The nicotine content of tobacco is sufficiently high to produce definite changes in the muscular activity of the entire digestive tract. Nicotine acts on the central nervous system and results in marked stimulation of the cerebrospinal axis. Through the vagus and pelvic visceral nerves it causes a marked increase in tonus and contractions of the musculature of the digestive tube. Nicotine also acts directly upon isolated denervated sections of smooth muscle obtained from

the digestive tube and causes marked increase in irritability to stimuli and increases the amplitude of contraction even in fatigued muscle segments. Absolute abstinence from the use of tobacco in any form is imperatively indicated in the management of peptic ulcer.

Vitamin concentrates are usually given empirically. In instances of severe persistent spasm, antispasmodics are administered, usually ephedrine sulphate and amytal, ephedrine by virtue of its sympathetic stimulation usually very effectively and promptly relaxes muscle spasm in the digestive tract.

The above outlined procedures have a very happy effect in the general bodily economy, usually resulting in improvement in general health, increase in weight and a feeling of well-being both physical and mental.

COMPLICATIONS OF PEPTIC ULCER AND THEIR MANAGEMENT.

Obstruction, hemorrhage, perforation and malignant degeneration constitute the major local complications of peptic ulcer.

Obstruction usually occurs at or near the pylorus and may be due to hypertrophy of the pyloric sphincter, cicatrization at the pylorus, perigastritis, periduodenitis, pericholecystitis, tumor and many other less frequent causes. Obstruction may vary in degree from a slight delay in emptying time to a complete obstruction and usually develops gradually. As it develops the stomach undergoes characteristic compensatory changes similar to those observed in the heart. First, an increase in tonicity with probably greater peristaltic activity and associated with a probable well-marked hypertrophy of the gastric musculature. If the obstruction persists the stomach decompensates and gradual dilatation occurs. As dilation proceeds, the mucosa becomes stretched, the muscle fibres particularly of the fundal portion become more and more attenuated and separated and the contractility of the stomach wall becomes almost nil. One case has been seen where the muscle fibres were so spread and thinned out that violent vomiting caused multiple protrusions of the attenuated mucosa through the widely separated muscle bundles with rupture, without hemorrhage and without immediate shock.

Secretory changes parallel the muscular changes. During the early states of obstruction associated with peptic ulcer, the acid pepsin in the stomach content is of very high titer. As the fundal mucosa becomes more attenuated, the secretion frequently diminishes or vanishes.

The treatment of obstruction is primarily medical and is aimed at restoring the stomach to normal tonus and secretory activity. Surgical intervention during the period of decompensation is likely to result in disaster. Constant siphonage of the stomach through a nasal tube leaving the tube in place for as many days as necessary keeps the stomach constantly empty and allows the stomach to recover from its distention and stretching, with a later return of normal secretion. This it usually does very quickly, it seldom requiring more than five days of siphonage.

The large loss of chlorides and fluids are replaced by intravenous administration of at least 2.000 cc. of 5% glucose in normal salt solution daily. When the siphonage has reached a daily minimum the patient is fed thin cream of wheat or potato gruel; if this leaves the stomach within one hour the feedings are gradually increased. Frequently almost completely obstructed stomachs can be restored to approximately normal emptying time. These results are probably due to three factors, the reduction of inflammation around the lesion, resulting in less spasm, which permits the re-established muscle tone to force the food through the obstructed region.

If obstruction persists, surgery is definitely indicated. The patient has already been properly prepared, more or less normal tonicity has been restored to the stomach, mineral balance has been definitely improved, there is no dehydration or starvation acidosis. With this routine, few fatalities have occurred as a result of gastric or duodenal surgery. Postoperative complications have been definitely reduced.

Hemorrhage. According to various authorities, hemorrhage occurs as a complication of peptic ulcer in from 16 to 30% of cases. Treatment here is chiefly medical. Fatalities from hemorrhage in peptic ulcer probably do not exceed 1.5% under medical treatment. Certainly this constitutes a definite contraindication to surgery. Satisfactory results have been obtained by the following routine: complete bed rest with sedatives, preferably not an opiate; complete abstinence from any food or water by mouth; replacement of fluid loss by intravenous saline and glucose. Coagulents are used where the clotting time is slow; ice packs to the abdomen may be used. When bleeding has been severe,

repeated small transfusions are given. Feedings are resumed on the seventh day after hemorrhage has apparently stopped. If inanition is marked, feedings are resumed earlier at the physician's discretion. If bleeding persists, lavage with water at 120 degrees Fahrenheit is used. This usually will wash out the incomplete thrombi which are frequently responsible for continued bleeding. There may be a momentary gush of blood but usually the bleeding vessel dilates rapidly, discharging the imperfect clot and secondary contraction and retraction occur for a sufficient length of time to permit a complete clot to form.

Perforation. Perforations may be acute, subacute or chronic. They may extend into surrounding inflammatory tissues or directly into the lesser or greater peritoneal cavities. Treatment here ultimately must be surgical in the vast majority of cases.

Recurring postoperative or marginal ulcers. Time and space do not permit discussion of this complication. Suffice it to say that they constitute a major problem in treatment and resort to surgery should be had only when medical treatment has failed.

Carcinoma. There is a growing impression that perhaps many times carcinoma does not complicate ulcer but that ulcer is engrafted upon a primary carcinomatous lesion. Evidence as yet is not sufficient to establish this hypothesis. It is sometimes difficult to differentiate early carcinoma and ulcer. When apparent gastric ulcer persists in spite of all treatment operative interference seems justified. Fortunately primary carcinoma of the duodenum is almost an unknown disease unless it occurs at the ampulla of Vater.

SUMMARY AND CONCLUSION

I. Management of peptic ulcer should be primarily directed at removal of possible or probable causes.

II. Remote foci of infection doubtless constitute a major etiologic factor.

III. Remote abdominal visceral disease can and probably does supply sufficient reflex spasm in the stomach certainly, and the duodenum probably, to supply the trauma supposedly necessary to produce ulcer, in conjunction with infection.

IV. A simple practical and successful routine for treatment of uncomplicated ulcer has been outlined, consisting of three main objectives: rest, mental, physical and digestive; neutralization of acid pepsin secretion by diet and simple medication; regulation of habits, particularly the absolute necessity for restriction of tobacco in any form.

V. Management of the complications is outlined. The importance of proper preparation for surgery in obstruction is stressed. Treatment of hemorrhage is preponderantly medical; perforation usually surgical.

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DISCUSSION

Dr. J. Knox Simpson, Jacksonville:

Some few years ago, it was my privilege to hear a paper presented by Doctor Welch at a meeting of the Florida East Coast Medical Association and to see a graphic demonstration of his experiments in the motility of the gastro-intestinal tract under various conditions. I was very much interested in this work and in the part it probably plays in the production of peptic ulcer.

The opening paragraph in the present presentation, which contains this sentence: "It must be predicated upon a working knowledge of the physiology of the affected part or parts", states in a very terse manner the basis upon which all successful handling of the ulcer patient must depend. There are possibly certain basic requirements as a background for the formation and perpetuation of peptic ulcer. The essentials entering into this background are: first, increased trauma to the affected area, both chemically from hyperacidity and mechanically from hyperperistalsis and, second, a decrease in the resistance of the area to cellular disintegration which apparently may be due to small infarcts from focal infection, as brought out by Rosenow, and possibly from increased intracellular electrolysis producing cell destruction as a part of the increased metabolism which apparently occurs in these patients.

It is fascinating to read what Crile has to say on this subject in his monograph, "Diseases of Civilized Man." His contention is that because we do not rationalize the stimuli which come to our brain during these hectic days, neutralize them and cast them off, they are, therefore, projected through our brain into our autonomic nervous system as stimuli to the adrenal gland, the thyroid gland, and the various other pacemakers which in turn step-up all of our physio-

logic processes, producing hypertension, hyperthyroidism, hyperacidity, hyperperistalsis, increased pyloric contraction, etc. If this is true—and it probably is—it is a simple matter to visualize the sequence of events in our stomach and duodenum: hyperstimulation producing a closed pyloris for an excessive period of time; hypersecretion of acid occurring in a closed container; hyperperistalsis of stomach producing a stream of increased force, and increased acidity striking an area in the duodenum which is the most frequent site of ulcer.

Given this foundation, to which is added focal infection, the mechanical injury of highly seasoned food and strong drink, and poorly masticated food, and one has a perfect setting for the development of ulcer.

If one is to treat the ulcer patient, it is perfectly apparent that he must treat the patient who has the ulcer rather than treat an isolated ulcer which happens to be located inside a patient. In other words, Doctor Welch is standing upon firm ground when he emphasizes the care of the patient primarily and the ulcer secondarily. All treatment, whether medical or surgical, must have as its objective the overcoming of chemical trauma (hyperacidity); mechanical trauma (hypermotility and rough food) and mental trauma (emotional stress of various kinds.)

The choice of treatment, I feel, should always be medical in the following conditions: acute ulcers, chronic ulcers which have not had adequate medical attention, and as a preliminary to surgery in bleeding ulcers and ulcers producing obstruction. In the ulcers proximal to the pylorus, because of their tendency to malignant change, I think that medical treatment should not be persisted in if they do not promptly heal and leave no x-ray evidence of their presence. In other words, if the ulcer has left any demonstrable deformity or interference with the motility of the stomach proper after reasonable medical treatment, I think that surgical exploration followed by resection of the ulcer area is the safest procedure. My preference for surgical management of duodenal ulcers is, first, for resection of the ulcer accompanied by pyloroplasty after either the method of Judd, Horsley or Finney, and, second, for gastrojejunostomy if pyloroplasty is technically very difficult because of the extent of the ulcer or its inaccessibility.

I wish in closing to thank Doctor Welch for a most interesting presentation of this subject.

SOME "HIGH-LIGHTS" IN TUBERCULOSIS*

ARTHUR JONES LOGIE, M.D.,†
Chattahoochee.

In choosing the title of this paper, I intended to convey the impression that I meant to skim over some of the recent advances regarding tuberculosis, quoting extracts from the publications of authors occasionally, and to acquaint you with the work which we are doing here.

We realize that there are two types of tuberculosis which develop in the human body; 1, the first infection; 2, the reinfection type. The former, also known as the primary infection or childhood type of tuberculosis, begins to develop on tissues that are not allergic to tuberculoprotein. Allergy in tuberculosis is a state of hypersusceptibility to a foreign protein and constitutes the tissue reaction in an acute inflammatory manner to the protein of the tubercle bacillus to which the tissue is sensitive. In order to explain what is meant by tuberculoprotein, it is necessary to mention that the tubercle bacillus consists of two main parts: one, the protein portion, which is supposed to produce the allergy, and two, the lipoid portion, which is considered to produce the essential tuberculous lesion. When we use the term tuberculoprotein, we refer to the protein portion of the tubercle bacillus. "The natural defense mechanism of the body brings the first infection type under control and has it so encapsulated before allergy can be detected that it does little or no harm in most cases. This is the type of tuberculosis that formerly was prevalent among children but through anti-tuberculosis measures, many children now escape it and reach young adult life free from contamination with the tubercle bacillus. If they later come in contact with tuberculosis, as many nurses in training do, and are not adequately protected against exposure to patients suffering from tuberculosis, they take tubercle bacilli into their bodies and there takes place a non-specific tissue reaction with the production of allergy."[1]

In the reinfection type, which is also known as the secondary infection or adult type of tuberculosis, the tubercle bacillus invades already allergic tissue and a specific reaction occurs. "If the tubercle bacillus is not brought under control promptly, there is necrosis of the tissue as well

*Read before Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, Chattahoochee, April 10, 1936.

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as stimulation of fixed tissue cells, resulting in fibrosis. This is what is designated 'Clinical Tuberculosis.' It is the type that results in most of the illness and death from tuberculosis in the human family. Obviously, it can develop only in the bodies of persons whose tissues have previously become allergic to tuberculoprotein through the presence of the first infection type of tuberculosis. This type of disease may develop soon after the first infection renders the tissue allergic or at any subsequent time of life."[1]

At the Florida State Hospital, we are at present making a study of our student nurses. There has been much material published regarding the large percentage of the cases of tuberculosis reported among the students of nursing. Apparently, most of these are of the first infection type. Our routine is to do a Mantoux Intradermal Tuberculin Test on each student, using 0.1 cc. of a 1-10,000 or, if necessary, a 1-1,000 dilution of Old Tuberculin. To be called positive, a reaction must be, at the least, 5 mm. diameter in induration and 10 mm. diameter in erythema.[2] The reading is made in 48 hours. If a nurse shows a positive reaction, she has an x-ray plate made of her chest to determine whether there is any active pathology of the reinfection type present. All negative reactors will have the test repeated within 6 months of the first test, or sooner, should they show positive symptoms of a pulmonic nature. It is our intention to permit only positive reactors to work on the tuberculous wards, as negative reactors exposed to massive dosage of tubercle bacilli may receive a first infection type of a progressive nature, leading to rapid, endogenous reinfection with miliary type of spread. We believe that positive reactors have developed sufficient specific immunity to enable them to control small superinfections providing their general resistance is maintained at a high level and measures have been taken to prevent frank exposure, (Schick) and that, with negative reactors, it is advisable to postpone the first infection type as long as possible.[3]

The clinical manifestations of pulmonary tuberculosis are very variable, but we suspect the disease in any patient who has had a persistent cough for over six weeks, progressive and unaccountable loss of weight with malaise and lassitude. We inquire concerning hemoptysis, chest pain, history of pleurisy with effusion, and contact history. We then proceed to the general physical examination, laying emphasis upon the chest. A sputum smear is sent to the laboratory for search of the tubercle bacillus, and a postero-anterior chest film is requested. Should any of these investigations confirm our suspicions, the patient is transferred to the tuberculosis wards where, on admission, he receives a repeated chest examination. The following routine orders go immediately into effect: Request for a complete blood count, urinalysis, feces and urine examination for tubercle bacilli, blood sugar, and non-protein nitrogen, blood serology, blood sedimentation rate, and repeated sputum smear for tubercle bacilli.

Before segregating the patient among the active or open cases of pulmonary tuberculosis, we must find evidence of the tubercle bacillus. If the sputum on smear examination is negative, repeated concentrated examinations are done, using the antiformin method. Antiformin is the trade name of a mixture of sodium chloride and sodium hypochlorite which dissolves all organisms which are not acid-fast. Should these methods be of no avail, gastric lavage is done before breakfast and a concentrated examination of the stomach contents for tubercle bacilli is done. This method is very useful in children who are suspected of having tuberculosis, since children, especially those under five years of age, usually swallow their sputum. (Patients through the night swallow their sputum.) In a further search for the tubercle bacillus we culture on Petroff's egg medium or do a guinea pig innoculation. Petroff's medium consists fundamentally of veal extract, egg, and gentian violet. Gentian violet kills or prevents multiplication of all but acid-fast organisms. All sputum examinations are repeated monthly at the least.

The sedimentation rate is not only done on admission, but it is repeated periodically as it is of prognostic significance and also gives us indirect evidence of the progress of the active pathological process. We use the Brook's method and read the fall in the hematocrit every fifteen minutes for one hour. A fall over 70 mm. within the first fifteen minutes impresses us as of grave significance. The term, hematocrit, means, essentially, a type of centrifuge, but is now applied to the blood column which drops on sedimentation. Brook's sedimentation tubes are capillary tubes calibrated in mms. from 0-100. The bore is one mm. in diameter. The tube has an attachment for an intravenous needle at one end. The advantage of this method is its ease and rapidity.[4]

Routine postero-anterior chest plates are made in our department every three months on all tuberculous cases. We find that serial plates give us more thorough information regarding the progress of the lesions. Weights are charted weekly and physical examination of the chest is repeated every month on all active cases and every two months on inactive cases. Patients are graded according to activities, which are altered periodically, depending upon the patient's general condition. The activities range from 0-6, commencing with absolute bed rest and ascending to the grade at which the patient is permitted two to three hours a day out of doors.

All patients with long standing pulmonary lesions and having an enlarged spleen or enlarged liver or albuminuria receive the Congo Red test. This dye, using 10 cc. of 1 per cent sterile solution, is injected intravenously and a 10 cc. specimen of blood is withdrawn four minutes, and one hour after the injection. The percentage of the dye absorbed is estimated by a colorimetric comparison of the one hour specimen with the four minute specimen. If over 80 per cent of the dye has been absorbed, we feel that a diagnosis of amyloidosis is warranted (Ornstein). This test is repeated at a later interval for we feel that with the removal of the stimulating focus of infection, the amyloid change may undergo regression (Coryllos). This is shown by a lower absorption percentage of the dye when the test is repeated after the patient shows marked improvement in his condition. Amyloid disease or amyloidosis is a degeneration in which the connective tissue of various organs is converted into a translucent, firm, glassy, colorless material—albuminous in character. It occurs most frequently and abundantly in the liver, spleen, kidneys, and intestinal canal, respectively. It is of common occurrence in tuberculosis, syphilis, and in cachetic conditions. It is also seen in severe malaria, dysentery and locally in areas of chronic suppuration. It is thought that the degeneration is due to an infiltration by some abnormal material formed elsewhere in the body and conveyed to the affected tissues by the blood stream. Latest theory—it is a result of an endogenous protein metabolic disturbance with chronic hyperglobulinemia as an etiological factor in its production.[5] We suspect it in cases of tuberculosis when there is albumin in the urine and a palpably enlarged spleen or liver.

It is our intention to do a basal metabolic rate on all cooperative cases, for with tuberculous activity, the rate is increased except in extremely toxic cases.[6]

We find the Ornstein classification of pulmonary tuberculosis very convenient. This is a classification which takes into consideration the clinical, pathological, and radiological aspects of the tuberculous pulmonic lesions. It comprises four main divisions:

1. *Exudative Type:*

The patient is extremely sensitive to the tubercle bacillus and a small dosage results in an intense allergic response in the form of an exudative reaction. The onset is similar to an acute lobar pneumonia. After the climax, there is complete absorption and normal tissue is left. Clinically, the patient is acutely ill with a slight cough and scant expectoration. The physical signs are those of dullness, diminished breath sounds and a few fine rales over the affected area. The x-ray shows a more or less extensive, uniform shadow which may occupy an entire lobe. The prognosis is favorable as the condition is benign, usually clearing up in 6 to 10 weeks. It is usually not diagnosed until tubercle bacilli are found.

2. *Caseous Pneumonic Type:*

This is the classical type of pulmonary tuberculosis with intense destruction of tissue and cavitation. Clinically, sudden onset with great toxemia, etc.

3. *Exudative-Productive Type:*

This is a combination of the exudative and proliferative type. The onset, to a lesser degree, is similar to that of the caseous pneumonic, but no cavitation results. The exudation clears up and leaves central strands of scar tissue. This condition has a favorable prognosis and clears up in several months to a year.

4. *Chronic Proliferative Type:*

This type is due to a small dosage of tubercle bacilli and the presence of a slight allergy. There are few symptoms. It is the slow, drawn out type of pulmonary tuberculosis, and the essential change is predominantly that of fibrosis.

An individual may have any one or a combination of any of these types at the same time.

In the treatment of pulmonary tuberculosis, a high caloric, high vitamin diet consisting of 3,000 to 3,500 calories per day is advocated. Medication is given for symptomatic relief. In the fibroid type of pulmonary tuberculosis, tuberculin desensitization is carried out, using bacillary emulsion in a high dilution and in graded doses which are increased very gradually. In cases

with fairly stationary lung lesions but with such complications as laryngeal, intestinal, renal or bone tuberculosis, tuberculin desensitization in conjunction with carefully graded ultra-violet radiation is practiced, providing the patient has no high temperature and no recent hemoptysis. We also intend to practice the Rollier system of using natural sunlight as a therapeutic agent.

Artificial pneumothorax is induced in suitable cases with destructive lesions. We administer 200-300 cc. of air at the initial induction and repeat with similar refills each day for the first three days. It has been proved that the diseased pulmonic tissue is less elastic than the normal tissue (Coryllos). Consequently, it will collapse sooner than the normal tissue. For this reason we strive to obtain a selective collapse—that is, collapse of the diseased portion of the lung—by giving small and frequent refills as in many cases a bilateral pneumothorax is often necessary, also to allow more lung volume to function. Our routine in giving refills is to administer 150-200 cc. of air twice a week. The intervals between refills are prolonged if necessary, depending upon the rapidity of air absorption, amount of collapse of the lung, development of pleural effusion, and displacement of the mediastinum. The patient undergoing pneumothorax treatment is observed by the fluoroscope at least once a week. Reports of sputum smear examinations are graded by the Gaffky count from one to ten, depending upon the number of bacilli per slide or field—(microscopic). We expect, in a satisfactory pneumothorax case, a lowering of the Gaffky count of the sputum within a month and if pneumothorax is successful, a negative sputum in three to six months[8]. If pneumothorax is unsuccessful after a six month trial, other collapse measures must be considered. For pneumothorax to be effective as a curative measure, collapse of the lung must be maintained for at least a year and a half or two years.

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DERMATITIS VENENATA*

J. Lee Kirby-Smith, M.D.,
Jacksonville.

The invitation to attend your meeting tonight as your guest, and, too, to address you on the subject of some common skin disorder which is prevalent at this time of year, is greatly appreciated. Tonight I am bringing to your attention dermatitis venenata, an inflammation of the skin due to some recognized skin irritant. As a matter of fact most of you would naturally have in mind for this condition merely the occasional inflammation that is seen in contact with the common ivy vine (Rhus) and particularly so at this time of year, our spring. However, from years of experience in Florida I have found that ivy poison is of a minor consideration. Accordingly, I am roughly and briefly dividing the subject in this manner: dermatitis venenata from, 1. chemicals, 2. cosmetics, 3. plants.

1. *Dermatitis venenata due to chemicals.*

Taking up the first item I would emphasize the fact that so many of us have become careless in our chemical knowledge and as a result indiscriminately prescribe irritating preparations innocently or, you might say, ignorantly. It would be somewhat out of order to go into great detail in the matter of the preceding statement; however, one particular example should freshen your mind and clear up the subject greatly. It is a known fact that the vast majority of our population have a low grade vegetable fungus infection of the feet which is usually unknown to the patient. This mycotic infection ordinarily produces nothing more than a soft, and at times, malodorous condition between the toes. In the spring of the year this trouble usually becomes aggravated and is oftentimes accompanied by slightly itchy water blisters around the toes, and frequently there develop concurrently, small, slightly distended water blisters on the fingers and the palms of the hands, usually producing very slight subjective symptoms. At this stage some well-meaning friend or possibly some of our practitioners appear on the scene and treatment of a vigorous nature is begun.

With our present knowledge the condition of the hand is due to irritation of the sweat glands through the blood stream. We call it a dermatophytid, which usually automatically subsides with the proper treatment directed toward the

*Read by invitation, April, 1936, meeting of the Suwanee Medical Society, Lake City.

source of the infection, the feet. But instead of this the hands are treated with Whitfield's ointment, kerolysis ointment, bichloride of mercury or iodine, etc., and as a result you have a picture of a typical dermatitis venenata that may easily be suggestive of Rhus poisoning. From the patient you gather that he has the same trouble every spring. With superimposed secondary infections you have a miserable patient on your hands for weeks.

The matter of dermatitis on the hands of a worker with the facts of his occupation before you, would not require detective work. In Florida, since we are not engaged greatly in manufacturing, quite seldom do we have occasion to treat occupational dermatoses. I must admit that a number of cases of irritations of the hands have been seen due to work of employees in drugstores, "soda boys." I recall a few cases several years ago seen at a citrus fruit canning factory. Occasionally we hear of dentists, even doctors, with a disabling dermatoses of the hands developing from contact with certain chemicals.

At this point I will recite an instance of an unusual case of dermatitis venenata that occurred in your section which was solved by the patient. The individual had, for a number of years, a recurring itchy, vesicular irritation of his face and hands with somewhat the appearance of ivy poison. He was a storekeeper, of apparent good health, had no plants or shrubs around, rarely went in the woods and had not experienced any sickness. The dermatoses practically disappeared in the winter and would start up with great fire in the spring. The merchandise in his country store was general, for a turpentine camp. During the course of three years, visits to various doctors resulted in tonsillectomy, hemorrhoidectomy, teeth extraction, diets and all manner of medicines. As in the beginning mentioned, this patient accidentally uncovered the source of his skin irritation. It was pyrethrum, ordinary insect powder. It was in a mosquito section. He sold the powder by the pound and, too, used it extensively for smudging his store. A number of instances of dermatitis venenata due to pyrethrum have been reported.

2. *Dermititis venenata due to cosmetics.*

Hardly a week passes that I do not see in my office, in consultation, itchy skin irritations occurring on the face or neck. Most of the dermatoses are of a dry scaly nature, sharply defined. The eyelids and lateral sides of the neck are the most frequent sites. Without exaggeration I should say roughly I have had several hundred patients with this type of dermatitis during the past fifteen years and I cannot at the moment recall a single male victim. Time and time again a female patient is sent to me by an E. E. N. T. friend with a complaint of several years' duration, usually involving the eyelid with some conjunctivitis. Is the trouble directly a result of a visit to the beauty parlor or is it an undue sensitiveness developed from constant use of some ordinary apparently innocuous toilet article? It is a matter of considerable importance and one that we cannot work out clearly except from a clinical point of view. However, we do know that most of our perfumes in this country are imported from Europe and, instead of having as you would expect a plain vegetable perfume as rose, violet or heliotrope extract, the perfume is made from complicated synthetic chemicals. With it all, please do not think for an instant that I am insistent that our beautiful women leave off all their adornments. A non-allergic lipstick or face powder may be obtained, and some of our elderly ladies can continue to appear youthful. I will not go into any further details other than to mention a frequent reporting in our medical literature of unusual and discomforting dermatoses from cosmetic preparations and cosmetic treatments at beauty parlors.

3. *Dermatitis venenata due to plants, shrubs and flowers.*

Some sixty-odd shrubs, plants and flowers have been reported as having produced skin irritations. For most purposes we should consider the "poison ivy vine," Rhus Toxicodendron, the poison oak or sumac, Rhus Venenata; and the ordinary primrose that is so often found in households. Practically our entire state is covered with poison ivy and it is my impression that with constant exposure most of us have become immune to the irritating plant. However, new comers who have not become acclimated oftentimes develop an acute attack of ivy poison. The recognition of the trouble is usually made by the patient and the matter of relief is why he may consult us.

In bringing to a close this subject I would call your attention to the fact that we have a very reliable means of verifying a dermatitis venenata, *i. e.,* the patch test. The substance under suspicion is applied directly to the clean skin, and covered with a piece of sterile gauze, held in

place with adhesive plaster. The technique is simple. The positive test will show up in twenty-four to forty-eight hours with a skin irritation. The April 4, 1936, issue of the A. M. A. Medical Journal under "Current Comments", calls attention to the various skin tests, and the fact that the scratch test or intradermal test as used by so many of our practitioners is not reliable. There is a general agreement that the patch test is of considerable value in differentiating the cause of skin irritation. Desensitization has been practiced for a number of years. It requires considerable time and expense.

In closing I suppose you will care to ask questions in the matter of treatment of dermatitis venenata. Anticipating the same I will roughly outline a routine procedure.

1. Do not use on acute dermatitis of plant origin any oily or greasy preparation.
2. If available an aircooled ultraviolet ray treatment (full erythema dose) will bring about a prompt evolution.
3. Alcoholic preparations with salicylic acid or sugar of aluminum (aluminum acetate).
4. Continued wet dressings very hot or very cold of some mild antiseptic or astringent character, boric acid solution, black wash or saturated solution of hyposulphite of soda.
5. After the termination of the inflammation some simple emollient for comfort.

REMARKS ON UROGRAPHY AND CYSTOSCOPY*

JULIUS C. DAVIS, M.D.,
Quincy.

This paper is based on observation from more than five hundred urologic examinations during the past seven years.

A patient with the classical triad of symptoms; pain, tumor and hematuria, demands attention at once. In fact, any patient complaining of symptoms of the genitourinary tract with a questionable diagnosis should have a complete urological study including excretory or retrograde pyelography or both, unless specifically contraindicated. Acute infections, marked emaciation, huge hydronephrotic sac, large brachial stone and tuberculosis of the occluded type are contraindications. Many delicate and hypersensitive patients react violently to any form of mechanical irritation to the genitourinary tract, *i.e.*, marked prostration, chills and fever, while others go about their usual vocations, and drive many miles suffering no ill effects. Many patients suffering no ill effect from one cystoscopic examination may have a violent reaction at another time, having a ureterospasm requiring an opiate for relief. Many of these with contraindications to retrograde pyelography may be spared reactions by using the less taxing method of excretory or intravenous urography.

EXCRETORY UROGRAPHY

Excretory urography depends for successful visualization upon renal and extrarenal factors determining renal excretion. Latent uremia, poor concentration power, as parenchymatous renal disease with poor diuresis are responsible for many failures. Purulent kidney infections, tuberculosis and polycystic deformities, unless associated with stasis, give poor visualization. In lithiasis, hydronephrosis, pyelitis of pregnancy, anomalies, neoplasms, pyelonephritis, and chronic nephritis this method will suffice in about 50% of the cases. Patients who have been properly prepared and have had morphia will show the highest percentage of positive findings whether the excretory or retrograde method is used.

PREPARATION OF THE PATIENT

The amount of necessary preparation depends upon many factors: age, vitality, expediency of the necessity for examination, dehydration, cachexia and whether the patient is neurotic. The doubtful patient should be hospitalized and given glucose and Ringer's solution the afternoon before cystoscopy, an aperient, and a sedative to insure a good night's sleep. The next morning an enema should be given for the purpose of removing gas or residue of feces that may still remain in the colon. A glass of water should be given the patient every twenty minutes until about six glasses are taken, the last one an hour before the operation. Weak, nervous and neurotic patients should be given a hypodermic of pantopon or amytal or phenobarbital orally an hour before operation. The use of local anesthesia, 5 per cent novocaine or 2 per cent metycaine in the urethra for ten minutes before the introduction of the cystoscope will facilitate matters very much and cause less pain to the patient. Serenium or uro-phosphate should be given for one day before and for three days after pyelography.

*Read before the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, Chattahoochee, April 23, 1936.

PROCEDURE

The first step when ready to proceed with the introduction of the cystoscope is to note whether there is any stricture of the urethra, as from experience we know that many patients have been benefitted from cystoscopic examination when the findings were negative and they had been suffering from urgency, frequency and painful micturition, three cardinal symptoms of stricture in the female. The benefit was from the dilatation of the urethra incident to the passing of the scope. In the urethra we may also observe papillomata, ulcers, caruncles and infections. The male urethra should be sounded and sufficient dilatation made for the passage of the cystoscope. A survey of the bladder should be made before further procedure as there may be too much pathology and one may be adding insult to injury by pyelography or the passing of bougies or catheters into the ureters carrying infection from a purulent cystitis. There should be observed in the bladder of either sex the presence of tumors, papillomata, ulcers, malignancies, tubercular infection, ureterocele, calculi, type of infection present, diverticuli, bladder capacity, condition of the trigome, blood or pus coming from the ureter, whether functioning properly and the shape of the ureteral orifice; whether golf-hole, crater type or whether ulcerated or papillomatous growths are protruding.

PYELOGRAPHY

The normal ureter is 5 mm. in diameter and varies from 1.5 to 7 mm. in different individuals. The muscular coat is composed of three layers external and internal or longitudinal fibers and a middle layer of circular fiber. The longitudinal layers are uniform while the circular layer presents areas of hypertrophy that produce constrictions termed ring muscles. These circular rings represent relay stations for the peristaltic waves originating in the pelvic musculature and influenced by the autonomic nervous system. The foregoing statement gives a basis for the explanation of the physiologic mechanism for the expulsion of urine and also the logic of the production of ureterospasm as a result of stimulation and mechanical irritation. This may be produced by the catheter or the opaque fluid used for the pyelogram or from some endogenous substance that will, by increasing extreme peristalsis, cause a narrowing of the lumen and subsequent hydro-ureter and hydronephrosis. There are three consistent constricted areas, *i.e.*, entrance into pelvis, middle of abdominal portion and ureterovesical junction. The kidney pelvis capacity should be measured with a solution of boric acid gently instilled into the catheter with a Luer's syringe until the slightest pain is felt, but first the amount of residual urine if any in the pelvis should be noted. After the capacity of the kidney is determined that amount of opaque solution selected for the picture is slowly injected, preferably neo-skiodan or 12½ per cent sodium iodide. The picture is then made with the patient in the Trendenlenberg position with a tilt of five degrees. The Buckey is used with the tube tilted at the same degree, thirty inch distance. A five second exposure, 30 M. A. by 85 P.K.V., for a patient 150 pounds.

NORMAL PELVIS AND CALICES

Before being able to interpret an abnormal condition it is naturally necessary to be familiar with the many varied conditions that are normal. There are usually three large calices for each kidney with from one to five smaller calices for each large one. However, kidneys functioning perfectly normally have from one to five large calices, and these are of various shapes, as oval, square, elongated, symmetrical, rounded outline, tapering, and obliteration of major or minor calices. The position of the pelvis is generally outward and perpendicular, however; in ptosis we have lateral and right angle pelves.

The pathological conditions listed for various changes in the kidney are malignant and benign tumors, polycystic kidneys, hydronephrosis, calculi, and pyelectasis. In cortical tumors the major calices are elongated, flattened out and constricted; in pelvic tumors they are cut off and shortened. Where the pelvis is encroached upon there will be deformity and flattening. In obstruction of the pelvis there will be dilatation. In polycystic kidney the involved calices are broader than produced by other neoplasms and generally bilateral. In hydronephrosis there is dilatation due to constriction with partial obstruction at the pelvis or the obstruction may be lower down with a hydro-ureter as well. The filling defect, while not always characteristic, is almost universally present in tumors, and a tumor to be associated with a normal pelvis is extremely rare.

USES OF CYSTOSCOPE

Aside from visualization of the bladder and as a medium through which opaque solution may

be used for retrograde pyelography this instrument is very valuable for removing specimens from the bladder and ureteral orifice for diagnostic purposes; treatment of ureteral strictures, fulguration of ulcers and papillomatous areas in the bladder and recently implantation of radium needles in treating malignancies.

In conclusion let me say that urography and cystoscopy are the means of diagnosis and giving relief to heretofore many obscure conditions.

THE CORRECTION OF SOME PROBLEMS IN STATE MEDICINE*

HARRISON A. WALKER, M.D.,
Miami Beach.

The Florida East Coast Medical Association is now in its eighth scientific assembly. It is with sincere pleasure that I have this year been privileged and honored to serve as your President. The major portion of the success of this meeting must go to Dr. Reddin Britt, secretary. The splendid cooperation of Dr. E. C. Swift, acting in an advisory capacity has been invaluable. I wish also to mention Dr. Leigh Robinson, Dr. Edward Jelks, Dr. E. C. Hardee, and Dr. J. Ralston Wells, who have given unstintingly of their time, efforts and experience.

I will not dwell at any length with the details of organization of this Association since at the last meeting Dr. Leigh Robinson gave a complete and comprehensive summary of the history of the founding and succeeding progress of this organization. However, for the benefit of the new members, I feel that it is necessary to mention the essential ideas that prompted the formation of this Association. At its inception, it was inspired by the social and professional intercourse exchanged between the various medical societies of the East Coast; such as was engendered between Broward, Palm Beach and Dade Counties. In the past six years there certainly has been a better fellowship and closer acquaintanceship between its members.

Today as a profession we are in the midst of extremely trying times and uncertainties, which affect the whole world. The medical economic situation is such that it tends toward our deadly and surely approaching enemy, "State Medicine." Without a doubt, many of the members of the profession, especially in communities which have been affected by industrial depressions, may have had their status changed more than others. They, consequently, may be more affable toward accepting definite salaried propositions and possibly are willing to receive dictations from insurance companies, monopolies and other agencies that tend toward "State Medicine." There is far too great a number of doctors who are barely eking out a living for themselves and families by the practice of medicine, who also may feel themselves forced to accept "State Medicine."

This is the time when each member of the profession should strive to uphold in every way his heritage, envied by all other professions. It may sound well to make such statements, but to accomplish them is entirely different. Each county society, as an integral part of its State Association which likewise bears the same relationship to the American Medical Association, has the same duties to perform in working out this huge problem. The specific committee of the A. M. A., whose duty it is to attempt to solve this problem, has had many sessions with special committees appointed by the President of the United States, the Public Health Service, as well as with special commissions.

It is with sincere humility and sense of duty that I presume to offer a suggestion toward solution. I imagine that were I to scrutinize your countenances, I would have no difficulty in detecting mirth at these expressed thoughts. That such is the fact is one of the reasons we are in our present state. However, I risk becoming unpopular with those upon whose toes these suggestions would seem to tread.

My first thoughts are that the medical profession itself must offer a solution whereby the public and laity generally will be satisfied and still we, the medical profession, properly keep control in our own hands instead of those of layboards, committees, companies and commissions. Where, then, lies dissatisfaction of our present status that can be so remedied? In the first place, all sorts of attempts have been made to establish clubs wherein medical and hospital care shall be included in some definite sum per year; San Francisco, Chicago and the Bronx in New York are examples and without satisfaction. On the other hand, in New York State definite arrangements have been made in certain counties, wherein the hospital is sustained by both County and State for the care of their indigent, and still it functions for the care of private cases as well.

*Read before the Florida East Coast Medical Assn., St. Augustine, Nov. 1 and 2, 1935.

The laboratory and x-ray services for those who are indigent are placed at a minimum charge and requisitions are sent in to the County and State. May this not be a clue to our solution, were we to sell the idea to the A. M. A.?

This suggests that all hospitals be subsidized for any diagnostic laboratory services for indigents; from the Federal Government to the State; and from the State to the County. These matters could be handled and controlled by special legislation and organization of our own profession instead of the laity. In order to bring about these functions under medical control it would seem that the A. M. A. should properly intercede in Washington. Under such conditions some of the money now being dispensed by the FERA, the PWA and kindred organizations, could be handled by a Federal Medical Commission, appointed by Congress, through the A. M. A. This Medical Commission should have the power within itself to regulate Federal-to-State, and State-to-County dispensations.

It may seem, on first thought, that this is a strange way to attack this subject but, on further study, I think you will agree that it possesses some logic. To elaborate: by this scheme, indigent patients may be hospitalized at a cost not too great for the taxable unit, where the responsibility for the care of such patients properly belongs. A fair and reasonable fee for professional services is a logical and just part of the total cost to the responsible community. Also, that large class of patients, next in the scale, who do not require actual charity but whose earnings do not warrant expenditures of the magnitude usually involved, may be considered in a somewhat comparable scheme. Hospitalization in this group is notoriously low. It may be made a source of moderate steady income to the hospital. A scheme similar to that for indigents will make it possible for patients of this group to be hospitalized at less cost to each and at the same time the physician may have a better chance to receive remuneration for his services. The patient may then have the necessary laboratory services and the hospital be remunerated, by a partial subsidy, from the County, State or Federal Government.

While the suggested skeletal plan is very meager, I offer it for your consideration and elaboration.

It is more or less singular that this subject seems to be the one most often selected for discussion. It obviously should be for it lies at the roots of the problem of daily existence for the profession. Our graduates who are just entering the medical field are vitally interested, but no less so than the general practitioner. The specialist probably is not as interested now, but must become so.

Our peers in medicine may not be affected at present but in time they, too, may lose their incentive and marked distinction.

As the profession knows, such a situation would be a sad mistake which the laity, in turn, would all too soon realize.

In closing, may I say that the Florida East Coast Medical Association, as an adjunct to the State Association, has no purpose of duties to perform, other than presenting scientific programs and furthering professional social intercourse of its members. It does not intend in any way to deal with any of the problems or functions of the State Medical Association, nor do I. This discussion is brought to the attention of this body for the express purpose of scattering seed for thought. If someone more capable than myself can in any way get proper thoughts of solution through proper channels, the economic and legislative committees of State and A. M. A., I will be, indeed, grateful.

The past year has afforded me much pleasure and an increased knowledge of the problems of the medical profession and its internal workings, for which I am indebted to you. I wish to emphasize that that pleasure could not have been as great without the splendid cooperation of the official family and all committees. I would now like to bespeak the same hearty cooperation with your next President, to the greater glory and success of the Florida East Coast Medical Association.

ERRATA

In the article, "The Use of Protamine Insulin in the Hospital Management of Diabetes Mellitus", by Dr. Albert W. Lewis, Jr., of St. Augustine and Dr. Harold Bowcock of Atlanta, published in the December Journal, an error appeared. On page 283, under the caption "Comment", is the following sentence: "Insulin reactions have occurred in this series frequently." This sentence should have read: "Insulin reactions have occurred in this series *infrequently*."

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16. 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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INTRACRANIAL HEMORRHAGES OF THE NEW-BORN

When the orthopedic consultants of the Crippled Children's Bureau inform us that more than twenty-five per cent of the patients they see in their various clinics held over the State are the result of intracranial injuries, it behooves the medical profession to attempt to check this serious situation. In the United States fifty per cent of the babies are born dead or die in the neonatal period every year as a result of intracranial hemorrhages.

While occasionally intracranial hemorrhages are unavoidable, in the vast majority of cases they are monuments to deficient obstetrical technique and inadequate obstetrical knowledge. Every physician must suspect intracranial hemorrhages, either gross or miscroscopic, in a case where it is difficult to resuscitate the baby. This hemorrhage may absorb without giving any further immediate symptoms, or may be severe and cause the death or deformity of a child. Rarely will difficult resuscitation be due to interference with the fetal maternal exchange of oxygen and the resulting anoxemia.

Intracranial hemorrhages most frequently result from laceration of the dura, *i. e.*, the falx or tentorium, for of course in these structures lie the blood vessels supplying the brain. Conversely from the adult, the hemorrhage in the new born child is usually venous. The child who has a slow respiration; the child who has a well-established respiration which gradually becomes weaker; the child who shows a bulging fontanelle which results from intracranial hypertension; the child who has twitching of the face or extremities, or convulsions; the child who does not nurse well and will not respond to the suckling reflex when the lips are stimulated—is the one that very likely has an intracranial hemorrhage. Pathologically, these are found to be gross or microscopic (into the brain substance). If the hemorrhage is infratentorial, it affects the medulla oblongata and the cerebellum with resulting damage to the cardiac and respiratory center; as the result of which the infant is usually quite markedly cyanotic with a marked opisthotonos, or convulsive twitching. This type usually does not live. If the hemorrhage is supratentorial the respiratory efforts are but slightly disturbed, death is delayed and the child may be pale and opisthotonos will only be slight. There may also be a localization of symptoms referable to the area of the brain damaged by the hemorrhage. If the hemorrhage is in the ventricle, death is usually rapid with early convulsions.

The prognosis depends of course on the extent and amount of damage. Those with severe hemorrhages die immediately, or are born dead. If the hemorrhage has been severe but they live, they may have a cerebral spastic paralysis, mental defects, hydrocephalus, speech defects, strabismus, or even epilepsy. If the hemorrhage is less severe, the sequelae may occur later in life after the baby apparently is normal.

Prevention of such catastrophes depends upon adequate prenatal examination, determination of the position of the baby, the measurement of the maternal pelvis and the evaluation of any disproportion. When operative obstetrics are necessary, the gentle and correct application of forceps will do much to reduce trauma. A careful diagnosis of the position of the head before the forceps are applied will prevent the application of undue force on the wrong diameter of the child's head. Timely use of episiotomy will relieve unnecessary pressure on the fetal head. By more frequently employing forceps on the after coming head in breech presentations, we may still further reduce the incidents where undue force is applied to the baby's head. Adequate prenatal care and examination ascertains chronic disease in the mother and the development of toxemias which weaken

the fetus and make it more liable to trauma. Resuscitation will become necessary much more infrequently if the medical profession exercises more caution in the use of the various analgesics and soporifics during the labor period. Since the discussion which occurred last spring at the American Medical Association meeting in Kansas City on this subject, much has been written which emphasizes the danger of analgesics. The elimination of violent resuscitory methods by the physician will do much to prevent the increase of small, minute or insignificant cerebral hemorrhages to ones of momentous proportions. Even though a dead baby is considered an obstetric tragedy, a deformed, demented child is a greater tragedy.

The physician should be ready to administer whole blood intragluteally when there is the slightest suspicion of intracranial damages as evidenced by difficult resuscitation or twitching of the new born. Following this, cerebrospinal or cisterna puncture should be done immediately, first as a diagnostic procedure to determine the presence of blood within the cerebrospinal fluid and second, to withdraw such blood and decrease the resulting pressure, thus relieving the symptoms and preventing further damage. These parasenteses may have to be repeated several times and while they may seem formidable, are life-saving and deformity-preventing. It must be remembered that the infant suffering from intracranial injury will not nurse and therefore does not receive a sufficient amount of fluid or nutriment during the first few days of life. Therefore, it is imperative that these infants receive normal saline and glucose solutions parenterally to adequately sustain their metabolism.

WOMAN'S FIELD ARMY IN CANCER CONTROL WORK

As the various menaces to man's health and happiness reach a stage where a frontal attack on them is possible a mobilization of our resources against them is inevitable.

Tuberculosis, blindness, maternal health, child welfare, crippled children, the American Red Cross are names or phrases which offer a welcome challenge to public-spirited and sympathetic men and women all over the United States.

With the appearance of each new organization comes more need for self-sacrifice and public service. It would require superhuman qualities not to feel a little worry as the number of appeals continues to mount. In spite of this fact, however, mature thought and consideration have shown that in every instance the need is urgent and very real and that the new organization is well qualified to meet it.

The most recent group to mobilize its strength against a great and cruel scourge is the Woman's Field Army of the American Society for the Control of Cancer. This nation-wide organization of the women of America will conduct a steady and relentless war to save, not to take human life. It is the kind of happy wholesome fight against fear and ignorance in which everyone can and should willingly take part.

The enemy is a cold and subtle killer which last year took more than 140,000 lives in the United States alone. It has been estimated that there are between three and five hundred thousand sufferers from this disease alive today. Perhaps a half of them might be saved if knowledge of the signs and symptoms which might mean early cancer were given to them and if they were also strengthened by courage to act on that information without delay.

To the millions of our people whose relatives and friends have borne the cross of cancer the call to arms will come as a welcome and long-awaited summons. There will be a real and lasting satisfaction in enlisting as a soldier in a great fight. Cancer is no respecter of class, race, or creed. To combat it is a common task which will recognize no preference. It is a truly unifying and democratic undertaking which should mean all the more in the midst of a civilization torn with undemocratic claims for selfish rewards.

The fight will last long and will require both courage and patience. It must be a matter of personal responsibility undertaken willingly in memory of those who have suffered and for the protection of the hundreds of thousands who need no longer do so. No one is so busy that he can afford to neglect his part in the united effort to check the silent inroads of a cruel killer.

When in March the first enlistment campaign is conducted there will be hundreds of thousands who flock eagerly to the symbol of the drawn sword and who will gladly do their part to bring light and peace where the darkness of ignorance and the sorrow of fear now are found.

OBSTETRICS AND PEDIATRICS

Courses in obstetrics and pediatrics will be inaugurated in the northern part of Florida during the months of January and February. Six cities have been chosen for the lectures which will be within seventy-five miles of any locality. The same lectures will be repeated in each one of the six cities on succeeding nights of the same week. Therefore, if a physician misses the lecture in one locality, he may, by traveling an additional distance, hear the same lecture the following night. Each community will receive a different group of lecturers on the same night of the week for the six successive weeks.

In order to make the program of interest to all members of the medical profession, the Committee on Maternal and Child Health of the Florida Medical Association in cooperation with the Bureau of Maternal and Child Health of the State Board of Health have attempted to provide lecturers from the various specialties. The faculty which will conduct the courses of instruction is as follows:

Lectures on Obstetrics: Dr. E. L. King, formerly associated with Tulane University; Dr. Russell H. Oppenheimer, dean of Emory University; Dr. William H. Vogt, St. Louis University; Dr. Fred J. Taussig, Washington University of St. Louis; Dr. E. D. Plass, University of Iowa; and Dr. Frederick H. Falls, University of Illinois.

Lectures on Pediatrics: Dr. Robert A. Strong, Tulane University; Dr. William A. Mulherin, University of Georgia; Dr. H. R. Casparis, Vanderbilt University; Dr. Lawson Thornton, Orthopedic Surgeon, Atlanta; Dr. J. J. Shea, University of Tennessee; and Dr. Edward A. Park, Johns Hopkins University.

The itinerary of the group will be as follows: Marianna, January 12, 19, 26 and February 2, 9, 16; Pensacola, January 11, 18, 25 and February 1, 8, 15; Tallahassee, January 13, 20, 27 and February 3, 10, 17; Ocala, January 14, 21, 28 and February 5, 12, 19; Jacksonville, January 16, 23, 30 and February 6, 13 and 20.

The institutes are so constructed that they will give a review of the subject and at the same time bring to the practitioners of Florida the newer ideas which have been found to be practical and worthy of acceptance. In the communities where these programs will be presented, they are brought at the invitation of the local medical society. All members of the county medical societies are urged to attend the courses in obstetrics and pediatrics.

These medical educators are being brought to Florida at the expense of the Bureau of Maternal and Child Health of the Department of Labor under the Federal Social Security Board.

SECTIONAL MEETING—AMERICAN COLLEGE OF SURGEONS

During 1937 the American College of Surgeons is planning a Sectional Meeting to be held in Atlanta, Georgia, on February 3, 4, and 5. Headquarters will be at the Atlanta Biltmore Hotel, and the following states will participate: Georgia, Florida, North Carolina, South Carolina, Tennessee, Alabama, Mississippi, Louisiana.

An active Committee on Local Arrangements has plans in hand for a most interesting meeting. Dr. James L. Campbell is chairman, and Dr. D. Henry Poer is secretary of the Committee on Local Arrangements.

A general outline of the program is as follows:

WEDNESDAY, FEBRUARY 3

8:00– 9:00	Registration and general information for Fellows of the College, hospital representatives, and guests.
8:00– 9:00	Inspection of technical and scientific exhibits.
9:00–12:00	Operative and non-operative clinics at local hospitals, surgery and the surgical specialties.
10:00–12:00	Hospital conference.
12:00– 2:00	Inspection of technical and scientific exhibits.
2:00– 4:00	Medical motion pictures: 1. General surgery. 2. Eye, ear, nose and throat surgery.
2:00– 4.30	Hospital conference.
4:30– 5:00	Annual meeting, Fellows of the College.
5:00– 6:30	Inspection of technical and scientific exhibits.
7:00– 8:00	Medical motion pictures: 1. General surgery. 2. Eye, ear, nose and throat surgery.
8:00–10:00	Scientific meeting, general surgery.
8:00–10:00	Scientific meeting, eye, ear, nose and throat surgery.
8:00–10:00	Hospital round table conference.

THURSDAY, FEBRUARY 4

8:00– 9:00	Registration and general information for Fellows of the College, hospital representatives, and guests.
8:00– 9:00	Inspection of technical and scientific exhibits.
9:00–12:00	Operative and non-operative clinics at local hospitals, surgery and the surgical specialties.
9:30–12:00	Hospital conference, panel round table.
12:00– 2:00	Inspection of technical and scientific exhibits.
2:00– 4:30	Hospital conference.
2:00– 5:00	Scientific meeting, general surgery.
2:00– 5:00	Scientific meeting, eye, ear, nose and throat surgery.
5:00– 6:00	Inspection of technical and scientific exhibits.
7:00–10:00	Medical motion pictures: 1. General surgery and eye, ear, nose and throat surgery.
8:00–10:00	Community Health Meeting.

FRIDAY, FEBRUARY 5

8:00– 9:00	Registration and general information for Fellows of the College, hospital representatives, and guests.
8:00– 9:00	Inspection of technical and scientific exhibits.
9:00–12:00	Special clinics at local hospitals: (a) Cancer. (b) Fractures. (c) Eye, ear, nose and throat.
9:30–12:00	Hospital conference, panel round table.
12:00– 1:30	Inspection of technical and scientific exhibits.
1:30– 2:30	Medical motion pictures: 1. General surgery. 2. Eye, ear, nose and throat surgery.
2:00– 4:30	Hospital conference, demonstration.
2:30– 5:00	Scientific meeting, general surgery.
2:30– 5:00	Scientific meeting, eye, ear, nose and throat surgery.

This meeting will be of interest not only to Fellows of the College but to the medical profession at large, and in addition, hospital trustees, superintendents, nurses, and other hospital departmental personnel are invited to attend the hospital conference.

There will be no registration fee.

REPORT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE

At a recent meeting of the Committee on Medical Post-Graduate Course of the Florida Medical Association, the treasurer, Dr. G. C. Tillman, presented the financial report for 1936, as follows:

FINANCIAL STATEMENT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE, 1936

Balance in Bank, Jan. 1, 1936		$500.26
Receipts:		
Registrations: 99 at $5.00	495.00	
		$995.26
Bills paid:		
Doctor T. Z. Cason (stamps)	10.00	
Doctor T. Z. Cason (stamps, telegrams, etc.)	10.00	
B. C. Riley (Dean, Extension Department)	100.00	
Hotel Thomas	106.35	
Accounts of:		
Doctor Edwards $ 6.00		
Doctor Schwarz 14.11		
Captain Jensen 19.19		
Doctor Bethea 42.90		
Doctor Davison 24.15		
White House Hotel	9.00	
Account of:		
Doctor Novak 9.00		
Pepper Printing Company (printing)	10.50	
Doctor C. R. Edwards (expense account)	52.00	
Doctor Emil Novak (expense account)	64.00	
S. L. Scruggs (Chairman, American Legion)	12.00	
Russell Mitchell (Student assistant)	6.00	
Burns Dobbins (Student assistant)	10.00	
Captain Jensen (expense account)	116.00	
Doctor O. W. Bethea (expense account)	45.00	
Telegrams and stamps	4.90	
Bank tax	1.00	
		556.75
Balance		$438.51

FLORIDA MEDICAL ASSOCIATION GRADUATE COURSE, INC.

(Signed) GEORGE C. TILLMAN, M.D.,
Treasurer.

The members of the committee expressed themselves as proud to have been able to arrange four such excellent courses as have been presented since the project first began in 1932 at a cost of only $61.49. The first two years the fund from the $5.00 registration fees amounted to slightly more than the expenses of the course. The excess went into the committee treasury. The third year the program was more elaborate and the expenses such that at the end of 1935 there remained in the treasury a balance of $.26 in addition to the sinking fund of $500.00 appropriated by the Florida Medical Association for the work of the committee. In 1936 the expenses of teachers coming from as far away as Texas

and Missouri raised the total expense to $556.75 or $61.49 more than the amount obtained from the registration fees. The committee expects to replace this small deficit and materially increase the fund for the improvement of the short courses by the change to Orlando for the session next June. Interest in the 1937 course has been stimulated already by the announcement of the change. A number of county medical societies have pledged their wholehearted support of the experiment.

STATE NEWS ITEMS

Dr. J. S. Turberville of Century, councilor for the First District, has been very active recently. Doctor Turberville invited a group of physicians in Washington and Holmes counties to be his guests at Century recently and those present decided to reorganize the Washington-Holmes County Medical Society and to make formal application for a charter. There seems to be considerable enthusiasm among the doctors of these two counties for an active society and Doctor Turberville, the councilor for this district, is to be congratulated on his constructive work in crystallizing the action.

* * *

Dr. and Mrs. Henry Hanson, their daughter, Martha, and son, Virgil, spent ten days in Riobamba and Quito, Ecuador, during the last few days of November and first week in December. On the 14th of December, Dr. Hanson and family flew in a Pabagra "Baby Clipper" from Quayaquil to Lima, Peru. The family will reside in Lima while the Doctor continues his work for the Pan American Sanitary Bureau in Ecuador and Peru. His work to date has been mainly with bubonic plague.

* * *

The annual meeting of the Staff of the Victoria Hospital, Miami, was held December 28, at 8:30 p. m., Dr. R. N. Burch presiding. After the minutes of the last meeting and the hospital record for November had been read and accepted, a report of the nominating committee, headed by Dr. Homer Pearson, was read. The following officers were elected for 1937: president, W. A. Haggard; vice-president, Taylor Lewis; secretary, James J. Nugent. Dr. Donald Smith was nominated and elected to the Victoria Hospital staff.

The Florida State Hospital at Chattahoochee is to have a staff of consulting specialists as a step toward gaining recognition as a standard hospital. The Board of Commissioners of State Institutions recently appointed the following consultants upon recommendation of Dr. Ralph Stevens, the Hospital's chief physician: Ralph Greene, Coral Gables; H. Mason Smith, Tampa; W. H. Spiers of Orlando and W. C. McConnell of St. Petersburg. Dr. Smith is a former superintendent of the Hospital; Dr. Greene and Dr. Spiers former chief physicians; and Dr. McConnell is a former member of the medical staff. These consultants will serve without compensation.

* * *

Dr. F. A. Gowdy of Ft. Pierce has moved to Miami Beach where his address is 6780 Collins Avenue.

* * *

Dr. Harry A. Wakefield of West Palm Beach has returned from a trip to New York City.

* * *

The First International Conference on Fever Therapy will hold its sessions on March 29, 30 and 31 at the College of Physicians and Surgeons, Columbia University, New York City. The first day will be devoted to the discussion of physiology, pathology, and methods of production of fever; the second day will be spent in the consideration of miscellaneous diseases treated by fever, such as chorea, rheumatic carditis, ocular diseases, arthritis, leprosy, meningococcus infections, undulant fever, tuberculosis, tumors, skin diseases, etc. The morning of the third day will be devoted to the consideration of syphilis and the afternoon to the treatment of gonorrhea by fever. Ministries of Health from many countries have indicated their intention to send official representatives to the Conference. All who plan to attend are urged to register promptly with the General Secretary, Dr. William Bierman, 471 Park Avenue, New York City. The registration fee is $15.00.

* * *

Dr. Reddin Britt of St. Augustine was recently elected president of the St. Johns County Welfare Federation.

* * *

Dr. W. L. Fitzgerald of Miami has moved his offices from the Huntington Building to Suite 422-423 Ingraham Building.

Drs. M. A. Lischkoff, J. J. McGuire, J. C. McSween and W. C. Payne of Pensacola attended the annual Tulane-L. S. U. football game in Baton Rouge, November 28.

* * *

Dr. B. B. Sory, Jr., has moved his offices from West Palm Beach to the Brazilian Court Hotel, Palm Beach.

* * *

Dr. Orville N. Nelson of the U. S. Veterans Hospital, Bay Pines, was elected a Fellow of the American College of Surgeons at the annual meeting of the College held in Philadelphia in October. Doctor Nelson was elected a member of the American Academy of Ophthalmology and Otolaryngology in September at a meeting of the Academy held in New York City.

* * *

Dr. J. D. Stuart of Miami has moved his offices from the Ingraham Building to 227 N. E. 5th St.

* * *

Dr. A. G. Holmes, who for some time has practiced at Daytona Beach, has returned to Miami where his address is 867 N. E. 76th Street.

* * *

Dr. Henry B. Oertel of Willow has moved his office to Osceola.

* * *

The many friends of Dr. J. Ralston Wells of Daytona Beach will regret to learn of the death of his father, P. Frailey Wells, M. D., on December 16 at Philadelphia. Doctor Wells, who was 77 years old at the time of his death, graduated from Pennsylvania in 1881 and practiced his profession for 55 years.

* * *

Dr. R. O. Cooley and Dr. W. O. Arnold have moved their offices from Myrtle Street to Flagler Drive, West Palm Beach, occupying a new building of their own.

* * *

Dr. J. M. Gorman of Jacksonville announces the removal of his office to the Peninsular Life Building.

* * *

Dr. W. M. Rowlett of Tampa was recently appointed a Colonel on Governor Cone's staff. He attended the inauguration at Tallahassee, January 5.

Dr. W. O. Arnold and Miss Olive Edith Schell of West Palm Beach were married on Saturday, December 5.

* * *

A Fellowship in Anesthesia was conferred upon Dr. Gaston Day of Jacksonville by the International College of Anesthetists at a recent meeting of the College held in Philadelphia.

* * *

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that out of the 88 applicants who took the Board examination held in Jacksonville November 16 and 17, twenty-eight failed to make a passing grade. The highest average, 88.3, was made by Dr. Herbert Eichert of Baltimore, a graduate of the University of Maryland in 1932. The second high average, 88.2, went to Dr. Donald Gareth McHale, who graduated from Jefferson in 1935. Following is a list of the successful applicants:

Arnow, Matthew, Jacksonville, Florida—Rush Medical College, 1936.
Ball, William Heath, Tampa, Florida—Virginia, 1931.
Barfield, Hugh H., Atlanta, Georgia—Emory, 1932.
Brooks, William Herman, Jacksonville, Florida—Georgia, 1933.
Burch, John Edward, Coral Gables, Florida—Louisiana S. U., 1935.
Caraway, Archibald F., Jr., Jacksonville, Florida—Tennessee, 1936.
Carmody, John Thomas, Chicopee Falls, Massachusetts—Yale, 1932.
Chamberlain, Eugene C., Madison, Florida — Western Reserve, 1933.
Christensen, Louis M. N. W., Orlando, Florida—Evangelists of California, 1936.
Clark, Irving T., Miami Beach, Florida—Buffalo, 1931.
Cohn, Milton, New York, New York—New York University, 1931.
Davis, Theodore McCann, Greenville, South Carolina—Maryland, 1914.
DeLay, William Dewey, Lake City, Florida—Vanderbilt, 1923.
Diehl, Earl Henry, Tampa, Florida—Maryland, 1935.
Dowlen, L. Washington, Miami, Florida—Tennessee, 1935.
Driscoll, Robert Hayes, Cheraw, South Carolina—Pittsburgh, 1935.
Drohomer, Peter A., Canton, North Carolina—Emory, 1934.
Eichert, Herbert, Baltimore, Maryland—Maryland, 1932.
Farrior, Joseph Brown, Tampa, Florida—Tulane, 1936.
Gallagher, Henry, Waskom, Texas—Tulane, 1929.
Gay, Clifford Jackson, Miami, Florida—Georgia, 1936.
Griggs, Thomas S., Coral Gables, Florida—Georgia, 1935.
Heath, Ralph Talmadge, Brooksville, Florida—Georgia, 1933.
Henderson, Major J., Tampa, Florida—Rush, 1936.
Hockenberry, Everett D., Pittsburgh, Pennsylvania — Pittsburgh, 1930.
Holland, Francis Turner, Tallahassee, Florida—Emory, 1933.

Holly, Julius David, Baltimore, Maryland—Maryland, 1921.
Holman, Norman W., Atlanta, Georgia—Emory, 1935.
Hurt, Floyd K., Jacksonville, Florida—Virginia, 1935.
Kugel, Maurice A., Fort Myers, Florida—Yale, 1926.
LaNasa, Matthew James, New Orleans, Louisiana—Tulane, 1932.
Lautzenheiser, Ross B., Miami, Florida—Syracuse, 1927.
Law, Otis H., Miami, Florida—Vanderbilt, 1936.
Lively, William McCain, Miami, Florida—Baylor, 1936.
Lobell, Abraham, New York, New York—Fordham, 1913.
Logie, Arthur J., Jacksonville, Florida—Royal College P. & S., Scotland, 1933.
Lustig, Julius, Panama City, Florida—Illinois U., 1934.
McCreary, Albert B., Jacksonville, Florida—Tennessee, 1922.
McHale, Donald Gareth, Miami Beach, Florida—Jefferson, 1935.
McKey, Earle Sinclair, Jr., Miami, Florida—Emory, 1936.
Norton, Harold Jacob, Columbus, Indiana—Cincinnati, 1924.
Pierce, Francis D., Jacksonville, Florida—Tulane, 1928.
Pomerance, Joseph B., Augusta, Georgia—Georgia, 1932.
Prigot, Aaron, New York, New York—Harvard, 1933.
Putnam, George Hamlin, Slocomb, Alabama—Rush, 1934.
Rand, Harold, Bay Pines, Florida — Western Reserve, 1932.
Renkoff, Herman, Miami Beach, Florida—Loyola, 1931.
Robbins, Alexander, Miami Beach, Florida—New York Med. Coll. and Flower Hospital, 1933.
Saslaw, Milton Sibley, Miami, Florida—Bellevue, 1934.
Scatliff, H. Kenneth, Chicago, Illinois—Herring, 1913.
Schumacher, Evelyn L., Sanford, Florida — Woman's Penn., 1935.
Smith, Malcolm McNeil, McRae, Georgia—Emory, 1926.
Stayer, Glenn Emory, Tampa, Florida—Duke, 1934.
Thomas, Efton Jewel, Miami, Florida—Northwestern, 1936.
Waering, Kolbein L. K., Jacksonville, Florida—Harvard, 1935.
Washington, Emmett (n), Jacksonville, Florida—Meharry, 1935.
Watson, John Laxton, Toronto, Canada—Toronto, 1926.
Wentzel, Willett Elmer, Oshkosh, Wisconsin — Northwestern, 1936.
White, Millard Brown, Tampa, Florida—Duke, 1935.
Whitmer, Kenneth, Miami, Florida—Ohio, 1936.

* * *

The Staff of the Flagler Hospital, St. Augustine, were hosts at a barbecue, well attended by Jacksonville doctors, on December 3. Dr. Herbert White was "Master of Barbecue."

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

DADE COUNTY MEDICAL SOCIETY FINISHED 1936 WITH A 100% PAID MEMBERSHIP CONSISTING OF 220 AFFILIATED DOCTORS. THIS IS THE FOURTH CONSECUTIVE YEAR THAT THE DADE COUNTY SOCIETY HAS BEEN 100% PAID WHICH IS, INDEED, A RECORD ACHIEVEMENT.

At the annual meeting of the Dade County Medical Society, the following officers were elected to service during 1937:

President—R. N. Burch.
Vice-President—John D. Milton.
Secretary—Walter C. Jones, Jr.
Treasurer—Sheffel Wright.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular meeting of the DeSoto-Hardee-Highlands County Medical Society was held December 8 in Arcadia. Dr. G. S. McKnight, president, was the presiding officer. Members present were: Drs. McKnight, McSwain, Bevis, Highsmith, Martin and J. H. Simmons. Dr. O. O. Feaster, president of the Florida Medical Association was guest speaker. The election of officers, held at this meeting, resulted as follows:

President—G. H. McSwain, Arcadia.
Vice-President—W. H. Peacock, Wauchula.
Sec'y-Treas.—L. W. Martin, Sebring.
Censor for three years—I. W. Chandler, Avon Park.

It was decided to hold the January meeting at Wauchula.

DUVAL COUNTY MEDICAL SOCIETY

A meeting of the Duval County Medical Society was held January 5 at the Mayflower Hotel at 8:15 p. m., preceded by highballs and a Dutch supper at the Hotel George Washington. Dr. Frank K. Boland of Atlanta was guest speaker, giving an address on "Amebiasis and Liver Abscess." About 125 doctors from Jacksonville, Lake City, St. Augustine and surrounding cities were present.

ESCAMBIA COUNTY MEDICAL SOCIETY

Election of officers of the Escambia County Medical Society was held Tuesday, December 8, with the following officers chosen:

President—J. C. McSween, Pensacola.
Vice-President—Rufus Thames, Milton.
Sec'y-Treas.—J. M. Hoffman, Pensacola.

MARION COUNTY MEDICAL SOCIETY

TO THE MARION COUNTY MEDICAL SOCIETY GOES THE HONOR OF BEING THE FIRST 100% PAID SOCIETY FOR 1937. THIS SOCIETY, WHICH IS COMPOSED OF TWENTY-ONE ACTIVE AND ONE HONORARY MEMBER, IS HEADED BY THE FOLLOWING OFFICERS TO WHOM MUST GO THE CREDIT FOR THIS SPLENDID ACHIEVEMENT:

President—RALPH E. RUSSELL, OCALA.

Vice-President—HENRY GATRELL, FAIRFIELD.

Sec'y-Treasurer—RICHARD C. CUMMING, OCALA.

Delegate to F. M. A.—R. D. FERGUSON, OCALA.

CONGRATULATIONS, MARION COUNTY MEDICAL SOCIETY!

ORANGE COUNTY MEDICAL SOCIETY

At the annual meeting of the Orange County Medical Society held in December, the following report was presented:

ANNUAL REPORT

The Orange County Medical Society began the year 1936 with 55 active members and one honorary member. During the year seven new members were added, Drs. E. L. Jewett, D. T. Rue, F. L. Quillman, G. E. Christie, R. B. Carson, H. S. Knowles, and B. F. Hart.

Dr. P. M. Lewis, for many years a member of our society, was voted an honorary membership.

One of our active members, Dr. Haynes Brinson of Kissimmee, was taken from us by death on January 7th.

Two members, Drs. H. B. Oertel, and G. E. Christie, were granted demits from our society to join elsewhere.

So we close the year with two honorary members and 58 active members.

Twelve regular meetings were held during the year. Our annual banquet was held January 16th at Dubsdread Country Club. The annual picnic and barbecue was held also at Dubsdread on Saturday, August 29th.

A special meeting was held June 27th at which time a dinner was given in honor of Dr. Emil Novak who was guest speaker. This dinner was held at the Orlando Country Club.

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★ *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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Seven papers were given by members of our society at the regular meetings. One educational moving picture reel was presented. A guest speaker, Dr. A. J. Logie, director of the State Bureau of Tuberculosis, presented a paper on the provision for the care of tuberculous patients of Florida.

At the twelve regular meetings we had a total attendance of 410.

Three of our members, Dr. Henderson, Dr. Gardner and Dr. Ingram have a perfect attendance record for the year.

At this meeting it is our duty to elect officers for the coming year: President, Vice-President, Secretary and Treasurer, one delegate to the state meeting to fill the vacancy of Dr. H. A. Day who is retiring, and his alternate, Dr. Meredith Mallory, who also retires at this time.

W. E. Sinclair, President;
J. A. Pines, Secretary.

The election of officers for 1937 was held which resulted as follows:

President—H. F. Harms, Orlando.

Vice-President—H. A. Day, Orlando.

Secretary—Hewitt Johnston, Orlando.

Treasurer—Spencer A. Folsom, Orlando.

Dr. H. A. Day was re-elected for a two-year term to serve as Delegate to the Florida Medical Association, and Dr. Meredith Mallory as Alternate for the same term.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held a dinner and informal dance at the Shrine Club, St. Petersburg, on the evening of December 18. Dr. O. O. Feaster, president of the Florida Medical Association, was principal speaker, choosing as his subject "History of Regular Medicine."

Dr. Morris Fishbein, editor of the Journal of the American Medical Association and Hygeia, will be the guest speaker at the annual meeting of the Florida Medical Association, April 5, 6, and 7, 1937, Vinoy Park Hotel, St. Petersburg.

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HERE AND THERE

CHARLATANISM

Charlatanism is as old as mankind. If one were to go back to the time of the Greeks he would find descriptions of cults that are not very unlike some of those in vogue today. One of the characteristics of quackery, however, is that an individual fad does not last indefinitely. It comes into prominence, soon reaches a peak and then disappears. This also applies to various healing cults, no matter how honestly they may have been conceived.

In this connection it is interesting to read the following quotation from Palmer, the leader of chiropractic, which was printed in the September issue of *Colorado Medicine:* "Chiropractic is doomed. You have drifted so far from the basic principles of chiropractic that you have lost your identity and brought the basic science bill on your heads. Twenty-eight chiropractic schools have been closed . . . you cannot defeat the ends of science. The basic science bills are the buckshot which we deserve for trespassing. When chiropractors preach and practice and try to become physicians, then it is justifiable for the medical men to educate the chiropractor".—*Neighborhood Health.* New York City Department of Health.

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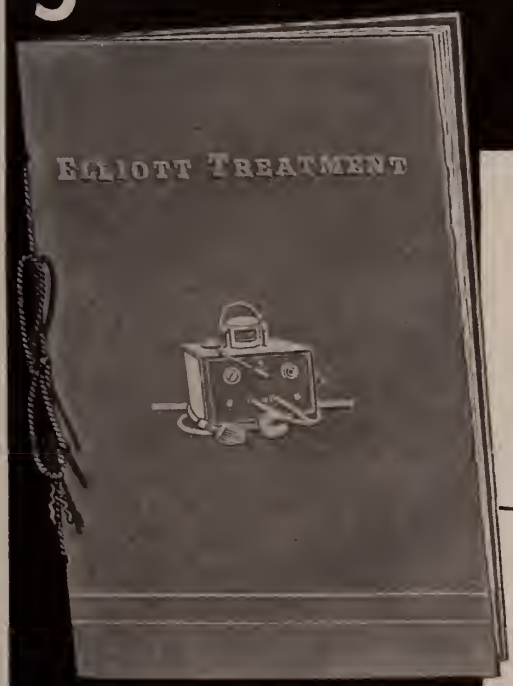
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I am wishing you all a Happy New Year from the cold and icy North but the day on which I write this letter here in Philadelphia is hardly any colder than our worst days in Florida. Do you see what I mean? At any rate, this is very strange December weather for Pennsylvania and I am expecting to awaken any morning and find the presence of a blizzard.

To get myself in the mood to write this page, I have been looking over the pages of the Pennsylvania Medical Journal for November and it is very comforting to find that we are all doing the same things. There may be a great many more of them and they do use four and a half pages in the Journal but the reports which came in to me last month of our Florida activities are proportionately just as good.

For instance, I am sure that none of their card parties were any more successful than the one which our Orange County Auxiliary gave for the benefit of their work with the Tuberculosis unit. They cleared $75 on that and, as if that were not enough, the Auxiliary is also helping in the sale of Christmas seals. These active women also prepared a Christmas box for the Children's Home Society.

In Pinellas County, the Auxiliary helped with tuberculosis work for they purchased a Tuberculosis Bond and they, too, helped to furnish Christmas cheer for children by a contribution to the Empty Stocking Fund. Husbands were guests of honor at a tea on December 7th when the Auxiliary entertained the Pinellas County Medical Society at Millgate, the home of Dr. and Mrs. Alvin Mills. Guests were received by Mrs. F. W. Roush, president of the Auxiliary; Mrs. W. W. Harden, president of the State Auxiliary; Mrs. Norval M. Marr, wife of the president of the Pinellas County Society; Mrs.



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O. O. Feaster, wife of the president of the State Association; and Mrs. J. A. Herring, wife of the appointed adviser to the Auxiliary. The tea was in charge of the hospitality committee of which Mrs. F. H. Langley is chairman. Music was arranged by Mrs. R. K. O'Brien, with solos by Mrs. C. B. Wright and Miss Virginia Roush.

The Alachua County Auxiliary also believes in entertaining the Medical Society. Dr. and Mrs. Edwin Andrews were the host and hostess at a delightful boat ride and supper at the Island Hotel at Cedar Key on December 12.

No reports have come in to me yet about an Auxiliary sponsoring one of the essay contests in which our president, Mrs. Harden, and our adviser, Dr. Ira, are so interested. Let's start to work on that now that the holidays are over. And don't forget that we want each Auxiliary, in cooperation with their Medical Society, to sponsor a cancer education program for the public.

Happy New Year to you all!

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SUMMARY OF NOVEMBER ISSUE

The efficacy of milk as a carrier of vitamin D as a prophylactic against rickets is brought out in the extensive clinical study reported in Abstract No. 118.

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Successful treatment of cardiac enlargement by dietary means is described in the article reviewed in Abstract No. 119.

Certified milk is advocated in Abstract No. 120 as especially well suited in the diets of children after the age of infancy, and the advantages of this superior grade of milk are set forth.

Celiac disease can be successfully overcome with high vitamin diets, according to Abstract No. 121.

Banana therapy is useful in the dietary treatment of diarrheal diseases, as shown in Abstract No. 122.

A comprehensive discussion of nutrition in relation to health and disease by an international authority is the subject of Abstract No. 123.

Powdered milk tablets containing alkalies proved advantageous in the treatment of peptic ulcer, as reported in Abstract No. 124.

The effects of liberal intakes of calcium in promoting healthful growth are revealed by the study outlined in Abstract No. 125. Powdered whole milk was the source of calcium in this investigation.

Similar growth effects due to increased protein are reported in Abstract No. 126.

Undulant fever is discussed in Abstract No. 127.



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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville		
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville				
Brevard	I. F. Bean, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies		
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale		
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City		
Dade	R. N. Burch, M.D., 1774 S.W. Eighth St. Miami	Walter C. Jones, Jr., M.D., 802 Huntington Bldg. Miami	1st Friday 8:30 P.M.	Elks Club		
DeSoto-Hardee-Highlands	Gordon H. McSwain M.D., Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies		
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Hillsborough	George L. Cook, M.D., 443 W. Lafayette Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa		
Jackson	C. H. Ryals, M.D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna		
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Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison				
Manatee	S. G. Hollingsworth, M. D. 451 12th. St. Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton		
Marion	Ralph E. Russell, M.D., Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	21	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies		
Orange	F. H. Harms, M.D., 64 No. Court St. Orlando	Hewitt Johnston, M.D., Box 2002 Orlando	3rd Wednesday 8:30 P.M.	Varies		
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach		
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Pinellas	N. M. Marr, M.D 812 Power & Light Bldg., St. Petershurg	W. C. McConnell, M. D. 1005 Equitable Bldg. St. Petersburg	1st. and 3rd. Friday 6:30 P.M.	Shrine Club St. Petershurg	37	43%
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Sarasota	Arthur O. Morton, M.D., Commercial Court Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday. 8:30 P.M.	Varies		
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford		
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Taylor	J. C. Ellis, M.D., Perry	J. L. Weeks, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry		
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Cbowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies		
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies		

NOTE—Secretaries: Please submit information to complete the above schedule.



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THE NEW YORK ACADEMY OF MEDICINE
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VOLUME XXIII
NO. 8

Jacksonville, Florida, February, 1937

Yearly Subscription, $3.00
This Copy $1.00

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American Medical Association, Atlantic City, June 7-11, 1937.
Southern Medical Association, New Orleans, November 30-December 3, 1937.

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Another report indicates a loss in vitamin C of 78 per cent in spinach stored two days at room temperature and 80 per cent loss in asparagus tips during four days' storage (2).

The vitamin C content of apples is markedly reduced during cold storage: 20 per cent in 4 to 6 months and about 40 per cent in 8 to 10 months (3).

Vitamin A in apples is, however, subject to less destruction than vitamin C during prolonged storage (4).

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Further, solution losses which may occur during cooking vary with the individual product and with the method used in cooking. From 40 to 48 per cent of vitamin C may be lost to the water in which peas are cooked (6).

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These data demonstrate the seriousness of solution losses of vitamin C. It is considered probable that other water soluble vitamins are affected in a similar way.

Thus, by the time fruits and vegetables spend some days in transit or storage before reaching the kitchen and are cooked by the usual home method, much of the original vitamin content may have been lost. Little can be done to prevent storage losses when fresh fruits and vegetables are not available from the home garden, but solution losses may in part be overcome by using the cooking water.

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(1) 1936. Food Research 1, 1.
(2) 1936. J. Soc. Chem. Ind. 55, 153T.
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b. 1928. Ind. Eng. Chem. 20, 202
c. 1929. Ibid. 21, 347
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References: Kugelmass, Clinical Nutrition in Infancy and Childhood, Lippincott; Marriott, Infant Nutrition, Mosby; McClean & Fales, Scientific Feeding in Infancy, Lea & Febiger.

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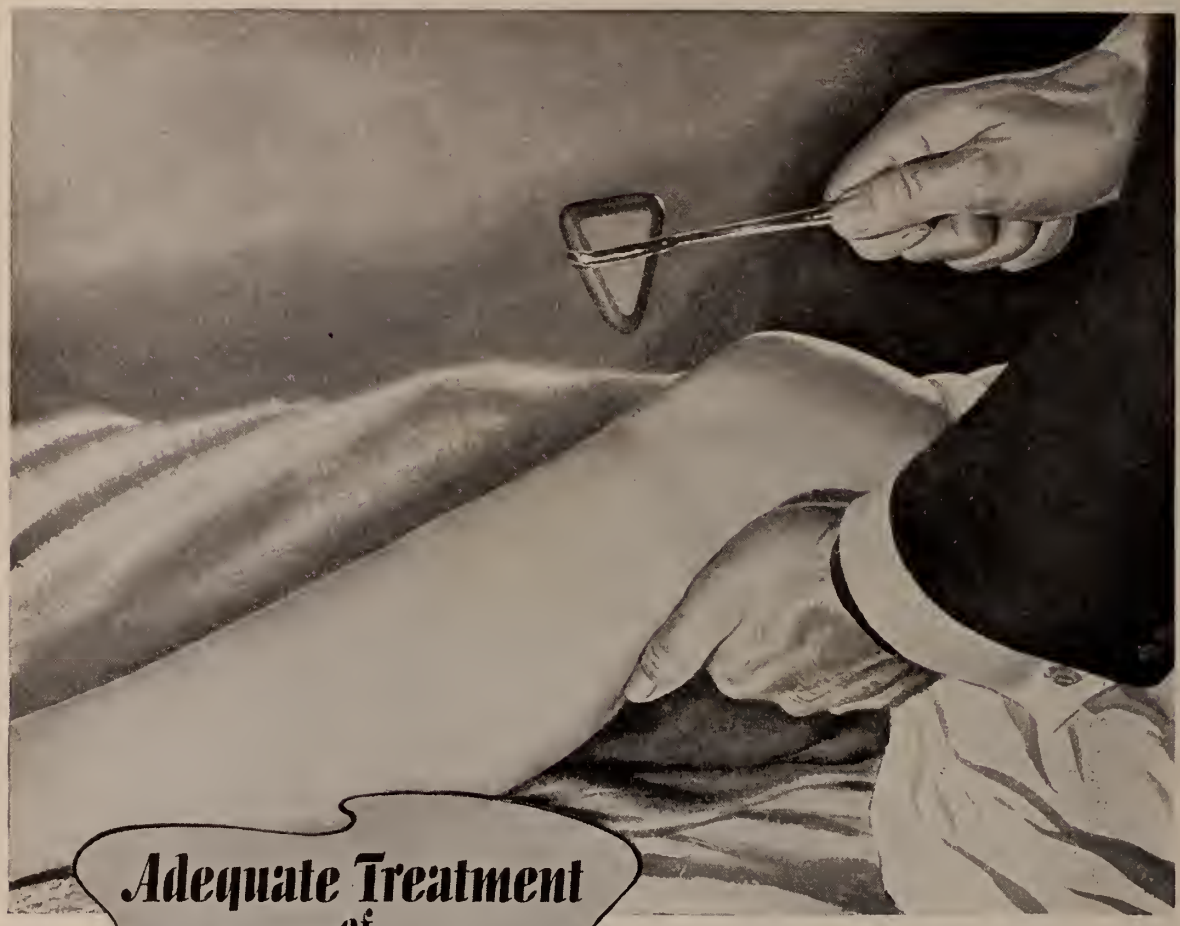
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXIII | Jacksonville, Florida, February, 1937 | Number 8

THE SYSTOLIC MURMUR, ITS INTERPRETATION*

S. Marion Salley, M.D.,
Miami.

The problem of the systolic murmur and its significance, although as old as the art of auscultation, is still a perplexing one to the practitioner. Dr. James H. Herrick has said: "Our fathers in physical diagnosis, when they wrote the chapter on the diagnosis of heart disease must have put in the systolic murmur to make it more difficult."

It is well known that although systolic murmurs often prove to be of no importance, they frequently prove to have a definite significance and a significance that can be explained. They frequently are the key to a diagnosis other than cardiac disease.

In any discussion of the systolic murmur the first condition which comes to mind is mitral insufficiency. Mitral insufficiency, however, does not necessarily mean disease of the mitral valve. A dilated left ventricle from hypertensive, syphilitic, or myocardial disease of any kind may cause the mitral orifice to increase in size and thus allow a regurgitation of blood. On the other hand, the valve itself may be diseased and the leaflets retracted causing an organic mitral insufficiency. The heart with the relative insufficiency may be in a more serious condition than the heart with the organic insufficiency for the underlying condition of the heart muscle is the point of major consideration.

A systolic murmur may also result from various congenital defects such as septum defects, coarctation of the aorta and the like. The possibility of congenital heart disease should always be borne in mind and an attempt made to diagnose the type of defect. I once saw the correct diagnosis of a case of Fallot's tetralogy made by an alert clinician after the case had been dismissed under the blanket diagnosis of congenital heart disease by an excellent cardiologist. It is well to assume the presence of organic heart disease where the heart is found to be enlarged, or where a definite history of rheumatic fever is obtained with a systolic murmur present.

In those cases where a systolic murmur is present with no other evidence of heart disease a careful history is of greatest importance. To mention only a few examples, it may bring to light a luetic infection, a definite or suggestive attack of rheumatic fever, evidence that a murmur had been present from infancy, or a previous hypertension may be uncovered.

The two most important factors in the consideration of what constitutes a systolic murmur are: first, duration and, second, intensity. The duration of the bruit must be more than a slurring of the first heart sound. It must extend definitely into the interval between the first and second sounds before it can be called a murmur. The intensity of the bruit is of next importance and we shall attempt here to classify these murmurs according to their intensity. It will be shown presently that this estimation can be of great help in evaluating the significance of systolic murmurs.

The following modification of Levine's[1] well-known classification of the systolic murmur has proven useful to me. We shall for the purposes of this discussion divide systolic murmurs into three grades according to their intensity. Grade 1 is the softest or faintest bruit that can be heard on careful auscultation. Grade 2 is a bruit of sufficient intensity to be easily heard and may be called moderate. Grade 3 we will call the loud murmur group and we shall include in this group all murmurs of more than moderate intensity, no matter how loud the murmur might be. The advantage of placing all murmurs of more than moderate intensity into one group is that they are, with few exceptions, due to obvious cardiovascular disease. It is the murmur of grade 1 or grade 2 intensity which is most frequently perplexing and which is most frequently seen. It is concerning the interpretation of these faint and moderate murmurs occurring without other evidence of heart disease, that I wish to speak.

In a recent study[2] of 900 consecutive cases from surgical wards, children's wards and from apparently healthy and normal individuals, plus

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the S.S. "Florida", April 27, 28 and 29, 1936.

100 cases from medical wards, there were found 196 cases (or roughly 20%) with murmurs of grades 1 or 2. There were found only 17 instances of a grade 3 murmur. All of the murmurs in the grade 3, or loud murmur group, were found in individuals with obvious cardiovascular disease. These loud or very loud murmurs are occasionally seen in cases other than cardiovascular disease such as acute leukemia with marked anemia, but here again their occurrence is usually readily explained.

The findings in the study of the 196 cases of faint or moderate murmurs are of interest. The following data were obtained with the various possible causative factors arranged in the order of their frequency.

(1) Twenty per cent had hypertension.
(2) In nine per cent there was discovered definite organic heart disease.
(3) Nine per cent were more than fifty years of age and it was felt that some of these no doubt had cardiovascular disease for cardiac enlargement and coronary disease could easily have escaped detection in this routine study.
(4) Eight per cent gave a history warranting a suspicion of a previous rheumatic state, such as growing pains, vague rheumatics, frequent sore throat and frequent epistaxis.
(5) In six and one-half per cent anemia was found, with a red blood count of less than 3,500,000.
(6) Six per cent gave a definite history of rheumatic fever or chorea.
(7) Four and one-half per cent had hyperthyroidism.
(8) There was a miscellaneous group of fourteen and one-half per cent in which were found various influences such as tertiary syphilis, leukemia, displaced heart and fever.
(9) There remained twenty-two and one-half per cent of these cases in which none of the above influences were found to explain the presence of a murmur.

It is interesting that in the group of unexplained murmurs three out of four had a murmur of only the faintest possible intensity.

These findings are in accord with the generally accepted view that hypertension, anemia, hyperthyroidism and fever are the most important factors to consider other than cardiac disease. It is significant that at least one or more of these factors were found in approximately thirty-five per cent of these cases where a murmur of only grade 1 or 2 was present.

The question which naturally arises, is why do systolic murmurs occur in these conditions? Blumgart, in his studies on blood velocity,[3] has shown that the rate of blood flow is increased in many of the conditions in which a systolic murmur is found. This is true of hyperthyroidism, pernicious anemia, following effort and during fever. In certain other conditions, such as emotion, neurocirculatory asthenia and certain cases of hypertension it may be that the presence of a systolic murmur is due to the same mechanism. Directly after brisk effort in practically all normal individuals a systolic murmur occurs temporarily. At this time the heart sounds are snapping in character and the velocity of blood flow is increased. (It is worth while to state here that the occurrence of this murmur after effort is no indication of cardiac pathology and it is usually only confusing to the examiner). We know from x-ray studies that in at least two of these conditions, namely, hyperthyroidism and following effort that the heart is either normal in size or smaller than normal and that dilatation therefore does not play a part in the production of the murmur. A systolic murmur which occurs in the absence of fever and with the heart rate slow, then assumes a greater significance than it would otherwise.

In regard to the way in which we should handle these cases it is hardly necessary to say that those cases where the systolic murmur is not found to be due to organic heart disease, need no cardiac treatment. This does not imply that those cases where the murmur is due to organic heart disease, should necessarily need treatment. Many of them, and this is especially true in young patients, need no restriction whatever. It is in keeping with the practice of the best cardiac clinics to place practically no restriction on young patients with only a faint systolic murmur to indicate the presence of organic heart disease.

In conclusion we may say that a systolic murmur which is loud is generally due to obvious cardiovascular disease. When it is faint or moderate it is frequently the key to the diagnosis of some condition other than cardiac disease. And finally, the patient with only a faint or moderate systolic murmur will seldom be found to need the restrictions usually considered necessary in treating obvious cardiovascular disease.

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DISCUSSION

Dr. W. W. McKibben, Miami:

The message Dr. Salley's fine paper carries, is a practical one. It is not right to invalid a well child. It is a real tragedy to find a little patient put to bed over a long period of time when he does not belong there at all. Yet, on the other hand, it is a tragedy not to recognize organic heart disease and not to treat it when present.

In 1919, in the pediatric section of the American Medical Association convention in Boston, the question came up as to whether a child should be told that he has a definite organic condition. With the exception of one doctor there, the opinion was that we should take the parents and child into our confidence, tell them its condition, and instruct them how to take care of the patient.

We are not always sure what causes functional heart murmurs in children; they are often present in acute fevers and in anemia. They may be cardiopulmonary, or due to obstruction or rotation or to thin blood; or possibly to relaxed pulmonary muscles.

These accidental cardiac murmurs are seen in from 65 to 70 per cent of children. They are systolic, loudest over base, pronounced at end of expiration in recumbent position, not heard during full inspiration, and not loudly transmitted to axilla and back. There should be no history, symptoms or signs of organic heart disease.

Dr. M. Jay Flipse, Miami:

I wish to reiterate the fact that the presence of a heart murmur does not establish a diagnosis of heart disease. It does indicate an abnormality in the circulatory mechanism. It is necessary to avoid giving digitalis to a patient merely because a heart murmur is discovered on physical examination.

It is also necessary to emphasize the fact that the presence of a murmur necessitates a careful cardiac study; this should consist of history and physical examination which includes inspection, palpation, percussion, auscultation and mensuration and also should include laboratory studies such as electrocardiograph, possibly polygraph and certainly x-ray and in addition it may be necessary to have the patient under observation for a period of time before an accurate diagnosis can be established.

Dr. S. Marion Salley, Miami (concluding):

I am glad that Dr. McKibben emphasized the point that the presence of a systolic murmur in children does not necessarily mean they need restriction. In children who have had rheumatic fever the importance of good nutrition should be emphasized. These children should be a little over weight rather than normal or under weight.

I am also glad that Dr. Flipse emphasized the importance of careful history taking and a complete study of these cases. We see too often the unfortunate results of an incomplete study.

I wish to thank these men for their discussions of this paper.

THE ROLE OF SINUSITIS IN THE PRODUCTION OF COUGH*

JOSEPH W. TAYLOR, M.D.,
Tampa.

Cough has been defined as a modified expiration of an explosive character designed essentially to remove a foreign body from the mucous membrane of the respiratory tract. While it can be, and frequently is, voluntary, it is more often a purely involuntary reflex act. Many times it is a mixture of the two—what Chevalier Jackson designated as "a reflex act reinforced by volition." As there seems to be a reflex element even in a voluntary act of coughing, it is important to consider the various possible origins of this reflex when endeavoring to discover and eradicate the stimulus to coughing.

That the stimulus to the cough reflex may be found in the upper air passages is not a very recent idea. About a half century ago, Hack in Germany, and Seiler in our own country, wrote papers concerning the part played by the nasal mucous membrane in the production of chronic cough. In 1883, John N. Mackenzie, of Baltimore, published a communication, the subject of which was "to direct attention to *the great frequency of cough as a symptom of nasal disease,* and to indicate as far as possible the manner of its production." Before writing his paper, he had conducted experiments upon hospital patients, upon himself, and upon a number of his "medical

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the S.S. "Florida", April 27, 28 and 29, 1936.

friends who were kind enough to place their nasal organs at the disposal of science." His conclusions did not point to the sinuses as the seat of the stimulus, for he states that "the sensitive area is principally confined to the posterior half of the inferior turbinated body and the posterior half of the septum."

While it is still recognized that, as Faulkner states, "irritation from the sinuses themselves can cause a reflex cough which is often troublesome," recent investigators have gone a step further to explain this troublesome cough. They have shown that sinus disease often results in infection of the lower respiratory tract, especially the bronchi and peribronchial lymph nodes, and that here is the seat of the resultant chronic cough.

Attention was called to these facts by two French army surgeons in 1916, (Rist and Sergent). These men noted that chronic cough and other symptoms suggestive of incipient tuberculosis were often associated with nasal sinus infection and relieved by treatment of the sinus disease. This was an important step forward. Such cases were usually diagnosed as tuberculosis, but on careful clinical study this diagnosis could not be confirmed, whereas the diagnosis of sinus disease with infection of the bronchi and peribronchial nodes became a tenable diagnosis.

In the United States, Mullin, of the Cleveland Clinic, has made a special study of the relationship between sinus and bronchial infection. Beginning in 1919, he noticed the frequent association of sinus disease with bronchitis and bronchiectasis, and undertook animal experiments to determine the routes of infection. In these experiments he demonstrated a route of lymphatic absorption from the sinuses to the bronchial, peribronchial, and mediastinal glands, and also the possibility of pulmonary and bronchial node infection by inhalation of infective material from the sinuses.

Clinically he noted that frequent chest colds may be the first evidence of the extension of sinus infection to the peribronchial glands and bronchi, "but a definite chronic bronchitis is eventually established and in a neglected case the final result is a bilateral bronchiectasis."

In 1932, Mullin stated that of 295 men patients with sinus disease seen at the Cleveland Clinic in 1931, "almost 20 per cent of them complained of cough, while in one-third of these, or nearly 7 per cent of the whole group, cough was the only symptom." The cough in these cases, he believes, is due to the infection of the bronchial, peribronchial, and mediastinal lymph nodes.

Webb and Gilbert reported in 1921 that since 1918 they had made it a rule to make a roentgenological study of the nasal sinuses in all cases of chronic cough and other symptoms of "chest disease." "Only a few cases of bronchiectasis or of chronic bronchitis have been found," they state, "in which chronic infection of the accessory sinuses was not demonstrated." They found that in some cases there was a pansinusitis; bilateral empyema of the antrums was most frequently encountered. Most of these patients (in 38 cases) gave no history of nasal discharge or pain, "or any sign suggesting nasal infection." The patients as a rule "were most surprised at the results of the investigations, having for the most part been treated over varying periods for pulmonary tuberculosis."

In 1927, Clerf, of the Jackson Bronchoscopic Clinic of Philadelphia, noted that in certain cases of bronchiectasis careful investigation of the nasal sinuses showed some form of chronic disease, either suppurative or hyperplastic. In these cases there was usually "a history of productive cough dating back to an infection in childhood or an attack of influenza, particularly one contracted during the recent epidemic."

He notes that another type of case is seen in the Clinic in which the symptoms suggest bronchiectasis, but roentgenograms and bronchoscopy do not show this condition. These cases occur most frequently in children. There is a history of recurring colds, especially in the winter, but the patient "is never completely free from cough, which is usually nonproductive and often the outstanding symptom." Physical examination shows signs of chronic bronchitis. The x-ray reveals heavy peribronchial shadows chiefly in the hilum; bronchoscopy discloses a low-grade bronchitis with scant but often tenacious secretion. There may be a widening of the carina and angles of division of the bronchi, but, as noted, no definite bronchiectasis. There are rarely any complaints referable to the nose, but careful examination shows chronic infection of the paranasal sinuses. These cases must be considered potential cases of bronchiectasis, and it is important to realize that the sinus infection must be treated in order to relieve the cough and the bronchitis and thus prevent development to the final stage of bronchiectasis.

Clerf, in one of his papers, concludes: "Examination of a patient with a chronic cough, with or without expectoration, is never complete until a careful study of the nasal accessory sinuses has been carried out; a negative opinion on sinus disease should not be given until every necessary diagnostic means has been utilized."

In a 1934 article, Clerf states that in slightly less than two hundred cases of bilateral bronchiectasis he has found nasal sinus disease in 82.4 per cent.

In an address before the Northern Medical Association of Philadelphia, Schwartz called special attention to the association between acute or subacute sinusitis and acute and recurrent bronchitis with its "annoying cough." He stated that a review of the literature of acute bronchitis for the past twenty years revealed nothing but "a repetition of the fact that it was an acute inflammation of the larger bronchi, and was characterized by an annoying cough with occasional discomfort over the chest. More recently it has been styled tracheobronchitis, indicating that the trachea is also involved; and very lately an occasional author mentions that rhinitis is a frequent complication or accompaniment. That the nasal accessory sinuses may be etiologically responsible or are perhaps involved in the same process is still little more than a secret, at least as far as the written word is concerned.

"Nevertheless, I am sure that most of you have not failed to observe that when such a patient presents himself with an acute, paroxysmal, dry or productive cough that he also has more or less nasal obstruction, and that later there is a thick mucopurulent or purulent nasal discharge. This discharge is not due to a simple congestion of the nasal mucosa; it comes from the recesses, cavities, and ramifications of that complex and tantalizing region, known as the nasal accessory sinuses."

Since 1930, reports of cases showing the close relation between sinus infection and bronchitis with chronic cough have been published more frequently. In 1931, J. D. Osmond reported that in the past four years he had seen a number of patients with symptoms suggesting early pulmonary tuberculosis, cough being a prominent symptom in all these cases, in which roentgenograms of the chest showed no evidence of tuberculosis, but rather "increased connective tissue branching out from each hilus region with no parenchymal involvement." In 124 such cases in which sinus examinations were made, definite sinus disease was found in 76. In these cases the history showed frequent head colds and increased expectoration.

The patient, however, Osmond notes, "may be entirely unaware of the presence of sinusitis." The most frequent subjective symptom is a moderate post-nasal dripping of mucus and "a tinge of yellow in the nasal secretions." In cases where a sinus infection was found, treatment for this condition resulted in relief of the cough and improvement in the patient's general condition.

On the basis of his clinical experience, McLaurin is convinced that "almost 100 per cent of all chronic tracheobronchitis, bronchitis, bronchiectasis, and peribronchitis cases are directly dependent upon some type of chronic sinus disease, with the exception of specific types of lung infection such as tuberculosis, pneumonia and syphilis, or lung abscess resulting from foreign bodies of various sorts, or the aspiration of infected tissue or material at the time of operation."

Uhr and Pugh, of the Vanderbilt Clinic, in 1933 reported a series of cases in children with frequent or almost constant colds, accompanied by spasmodic cough and nasal discharge. The cough was usually increased in frequency and severity by lying down. In many of these cases tonsillectomy and adenoidectomy had been done without relief. Transillumination and x-ray examination of the sinuses showed evidence of purulent sinusitis. This was treated by nasal irrigation and, in some cases, sinus irrigation through an antral puncture and instillation of a mild colloidal silver preparation with the use of an oily spray at home. When this condition was properly treated the cough was cured, the colds did not recur, and the patient's general condition was greatly improved.

In a recent (1934) article, C. G. Kerley notes that he sees many cases of persistent cough in children following mild colds in which x-ray study of the sinuses shows definite opacity, and in which the cough can be relieved only by treatment of the sinus infection.

The comparatively mild epidemic of the past fall and winter seemed to involve especially the sinuses. In previous epidemics, as you will probably recall, the mastoids and middle ear bore the brunt of the attack; at other times, the chest, accompanied by a large percentage of pneumonia.

Never has the writer seen so many acute sinus

infections during any comparable period. The maxillary sinuses were frequently filled with large quantities of thick, foul smelling secretion. The coughs complained of were extremely severe and could not be relieved by cough remedies and rest in bed. As a matter of fact, the cough was usually more troublesome when the patient was lying down, for which fact no explanation is offered.

The severe coughs were probably reflex in nature. By anesthesia, shrinking the turbinates, and also by removing infected secretions only temporary relief could be obtained. Permanent relief of the cough was secured only when the sinuses were restored to normal. During treatment, the cough improved in almost direct proportion to the clearing of the sinuses.

In a series of forty consecutive cases treated during the past fall and winter, cough was present in 80 per cent of all cases. Of these thirty-two, ten complained of cough as the only symptom. Twenty-two, in addition to coughing, gave a history of either a profuse nasal discharge or post nasal dripping. Eight, or 20 per cent, complained of pain over the maxillary sinuses, a symptom rarely present in the past.

In every case in this series the history revealed that the patient had had a cold of longer duration than the usual fortnight. Four weeks was the average. There was one patient who gave a history of cold-cough of ten weeks' duration. Age did not seem to be a factor; the youngest treated was seven years, the oldest, seventy-five. However, occupation seemed to play a part, more cases being seen among office workers and school children.

The treatment of sinusitis is not dealt with in this paper; however, a few brief case histories are presented for your consideration.

Case No. 1.—Miss M. S. Age 32. Welfare worker. First seen in the fall of 1935 with a history that six weeks previous to coming to the office she had contracted a severe cold. Various cold remedies were used. At the end of two weeks, the cold had apparently subsided, but there had been a persistent, productive cough for the past four weeks.

Examination—(General physical not included in these reports.) Transillumination, cloudy for maxillaries, frontals normal, x-ray showing clouding of both ethmoids and maxillaries apparently acute in character. Nose normal in appearance. Naso-pharyngoscope showed some pus coming from under the middle turbinates. Maxillary openings closed with granulation. Sphenoid area normal. Muco-pus in naso-pharynx. Tonsils had been removed. Pharynx and larynx normal in appearance.

Treatment—Maxillary sinuses irrigated through the natural ostium. Plenty of thick, greenish-yellow pus came from the sinuses. Cough improved after the first irrigation. It was thought advisable to make a window for more permanent drainage because this patient lived out of town and could not be seen often. Two weeks from the first treatment there was no secretion in the sinuses, and the cough had entirely disappeared. X-ray report three weeks later showed a remarkable clearing in the ethnoids and maxillaries.

Case No. 2.—Mrs. C. J. Age 34. Housewife.

Came in complaining of severe cough, worse at night and when lying down. The trouble had persisted for three weeks following an acute cold.

Examination—Transillumination, both maxillaries cloudy. The nose was congested, thick mucopurulent secretion coming from the natural ostium, bilateral. Heavy mucus postnasally.

Treatment—Irrigation of maxilliary sinuses through natural ostiums. Thick, heavy pus washed out from the maxillaries. A deflected septum to the right interfered with entrance to the natural ostium, therefore, a small window was made under the lower turbinate. On the other side, treatment was continued through the natural ostium.

Results—In two weeks the sinuses were dry and the cough had entirely disappeared. No difference could be seen in the time taken for recovery in the sinus that was treated through the natural opening and the one that had the window.

Case No. 3.—L. S., female, single, age 28. American. Occupation, nurse.

Cold for three weeks, severe cough two weeks. Profuse expectoration. Pain in right cheek, increased on stooping.

Examination—Transillumination, cloudy right maxillary, other sinuses clear. Rhinoscopic, turbinates boggy. Nasal scope, pus under middle turbinate and coming from antrum ostium, right side. Other sinus opening clear.

Treatment—Irrigation through natural ostium. Thick, heavy pus from right maxillary, from left, fluid returned clear. Two days later a window was made under lower turbinate of the right side. This was thought advisable because of a large

middle turbinate that interfered with irrigation through natural ostium. Three treatments, at two day intervals.

Result—Sinus clear, no pus, no cough.

Case No. 4.—Mr. L. R. W. Age 65. Retired.

Chief complaint—cold for the past three weeks. (Under treatment during this time without improvement.) Cough severe, especially marked when in the recumbent position. No nasal discharge. Slight postnasal drip.

Examination—Transillumination, cloudy for maxillaries. The frontal sinuses were negative. No secretion or inflammation was seen on casual inspection of the nose. Nasal scope revealed granulations over the maxillary ostiums. Throat negative.

X-ray report—"There is definite chronic thickening in the ethmoids and maxillaries."

Treatment—Irrigation through the natural openings. Plenty of thick, heavy pus washed out. As this case showed evidence of an acute exacerbation of a chronic sinusitis, an antrum window was made bilaterally. Several follow-up irrigations were done. At the end of five weeks the sinuses were dry. Cough relieved. No discharge. Re-x-rayed—showed marked improvement with only slight thickening in the mucous lining of the maxillaries.

Case No. 5.—Mr. W. P. B. Age 23. Bookkeeper.

Came in with a history of having a cold for the past five weeks. For the past three days there had been severe pain over the left eye and left side of the face. The nasal discharge was profuse, cough very severe, especially at night.

Examination—Turbinates swollen, heavy secretion under middle turbinates. Tenderness over frontal and maxillary sinuses. Nasal scope revealed pus coming from both maxillary ostiums. Irrigated a large amount of pus from both maxillaries.

X-ray showed an acute pansinusitis, all sinuses being involved with the exception of the right frontal.

Treatment—Right side irrigated through natural opening. On left side a window was made under the lower turbinate. Six weeks later sinuses dry. No cough or pain. X-ray at this time showed marked clearing of the frontals and ethmoids with a thickened lining of the maxillaries still remaining.

Case No. 6.—Miss F. M. Age 28. Occupation, bacteriologist.

Complained of persistent cough day and night during the past three weeks. Cough productive, especially in the morning and after eating. Slight nasal discharge. Postnasal drip.

Examination—Transillumination, cloudy for both maxillaries. Rhinoscopic pus coming from maxillary ostiums. X-ray (3/14/36) showed a diffuse clouding of the right frontal and ethmoids and marked opacity of the right maxillary. The left ethmoids and maxillary showed marked thickening of the mucous membrane lining.

Treatment—Irrigation through natural opening. Thick, greenish mucopurulent secretion was washed from both maxillaries. Three days later, patient reported that cough had stopped. No postnasal discharge. However, the sinuses were again irrigated and found to be dry.

On re-examination (4/9/36) the roentgenologist reported: "There has been a remarkable improvement in the sinuses since the examination of March fourteenth. Aside from very slight thickening of the mucous membrane lining of the maxillaries, I can see no evidence of pathology at this time."

SUMMARY

1. That prolonged, acute colds with a duration of more than a fortnight must be looked upon as sinus infections and not as simple colds.

2. Treatment by way of the natural opening, or through a window under the middle turbinate, must be determined by each individual case.

3. All persistent cough, of two weeks duration or longer, regardless of chest findings, should have a thorough examination of the nasal accessory sinuses.

4. Recognition and treatment of acute sinusitis prevents chronicity.

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DISCUSSION

Dr. Charles J. Heinberg, Pensacola:

I wish to congratulate Dr. Taylor on his timely and interesting paper. That infection can be, and is, transmitted from the nasal accessory sinuses to both neighboring and distant structures by continuity or contiguity of tissue, or by vascular and lymphatic channels has been proved. Thus, we can comprehend this being a source of metastatic infection.

Because the outlets of the sinuses are so located anatomically that they communicate with the nasal fossa and discharge their contents, when infection has occurred, purulent or infective material is emptied from them. Often we see patients with gastric disturbances from swallowing these secretions and reabsorbing the ptomaines. In like manner, when the head is lowered in sleep particularly, some of this material is aspirated, since the swallowing reflex is diminished, and secondary laryngitis, tracheitis and tracheobronchitis result.

Experiments have shown that radiopaque oils, dropped in the anterior nares of sleeping persons, could be demonstrated in the tracheobronchial tree the following morning by x-ray. So it is not unreasonable to believe, and understand, that infection from the sinuses follows the same procedure.

Reflex cough and other reflex pathology such as asthma have disappeared with elimination of the focus in the sinuses.

I think Dr. Taylor should emphasize his reference to coughs in children which, with colds, persist after tonsillectomy and adenoidectomy. These cases should be more fully investigated prior to operation.

Those cases of sinus pathology showing eosinophilia on smear of nasal secretions are to be considered medical and no surgery should be performed, at least until allergy has been improved or eliminated.

Cough is one of nature's protective symptoms and, as Dr. Taylor has emphasized, it is frequently a symptom of nasal disease and the general practitioner should bear in mind that the sinuses very often play an important part in its production.

Dr. R. E. Repass, Miami Beach:

I want to emphasize one point. Infection of the lymphoid tissue at the base of the tongue, the so-called lingual tonsil, frequently is responsible not only for persistent cough but the extremely annoying feeling of choking and constant tendency to clearing of the throat. These symptoms simulate, very closely, a globus hystericus. This lymphoid tissue is generally secondarily infected through blood or lymphatic channels or by continuity of tissue.

I have seen many such cases during our recent epidemic of acute upper respiratory disease. Vigorous treatment of this hypertrophic infected tissue results in prompt relief.

In cases of empyema of the maxillary sinuses, there may be a most persistent cough, paroxysmal in nature, when lying down, with severe paroxysms during the night. The reflex irritation is usually due to a nasopharyngitis, secondary to the sinus disease. Severe paroxysmal cough, particularly in children, with mucous rales all through their chests, that resist the customary measures of treatment generally means an acute ethmoiditis or other sinus infection, with secondary pharyngitis or lingual tonsillitis.

I think we can say this: that a persistent cough, associated with an acute or chronic bronchitis,

not due to cardiac insufficiency, or a bronchiectasis, not secondary to a chemical or obstructive lesion is, in the vast majority of instances, due to infection or disease of the paranasal sinus or contiguous tissue.

Dr. Joseph W. Taylor, Tampa (concluding):

These patients come to you primarily seeking relief of cough.

I am glad that Dr. Heinberg brought up the question of tonsils. That was also brought out by the last speaker. In a child, the parents are told that if they have a tonsillectomy the child will not have chronic colds and cough. But after the tonsils are removed the symptoms very often continue. We should bear in mind that a child can have sinus infection just the same as an adult.

In regard to infection of the lingual tonsil with nasal pharyngitis, I think the majority of these cases are due to direct infection by secretion dropping back into the nasal pharynx and downward to the base of the tongue.

PREVENTIVE MEDICINE AND THE PRACTITIONER*

W. A. McPhaul, M.D.,
State Health Officer,
Jacksonville.

State Medicine, Socialized Medicine, also sometimes called Health Insurance, has been defined as the assumption by the Government of the obligation to give every citizen medical and surgical care by physicians who receive no fees but are paid a salary by the Government.

Much has been said, much has been written and much thought has been given to this subject during the past few years. Especially has this been true during the trying times of the depression.

Dr. Kendall Emerson says: "Today we stand at an interesting midway point. Science both in medical and public fields has gone far beyond ten years' age and this midway position calls for the strongest bond between public health and private medicine. We must cooperate, otherwise a mutual loss becomes manifest."

The science of the private practitioner has achieved the high standing it now enjoys because of the individual relationships between physician and patient. For the best interest of both, this relationship must not be jeopardized.

I believe that the answer to State Medicine lies in a friendly and intelligent understanding between the practicing physician and the public health official. This understanding has grown steadily with the passing of each year. It is our duty and business to foster it, and between us work out plans which will be to the best interests of all the people.

The most important function of a health department is to educate and prevent. Curative medicine is solely the function of the private physician. Preventive medicine, however, falls within the province of both public health and private practice and it is here, in the field of preventive medicine, that public health and private practice must work closely together.

The part of public health in preventive medicine is to teach the masses of people the value of prevention. It is our part to make the general population aware of the benefits which preventive medicine has to offer. An educated public is a force stronger than sanitary laws. Private medicine, specifically in America, called Public Health into being. Hence, they are allies, each strong and useful to the other. Public Health was a natural outcropping of private medicine, brought about by the economic and sociologic changes which were taking place.

Public Health does not need to encroach upon private practice. As Medicine advances it will solve its problems. Public Health, as an adjunct, by its functions of education and prevention can assist Medicine. The limitations of public health will always be apparent, though I trust the field of public health will always benefit by every progressive step that Medicine itself makes. Again, I point out, that we must recognize public health and private practice as forces never in opposition but in alliance; two forceful factors at work for the public welfare.

It is a truism that "in union there is strength". If we consider the two great branches of medical service to the people, private practice and public health practice, as one whole, it seems to me that the bogey of State Medicine evaporates into very thin air. It becomes merely a label for a poor substitute which would be offered to the people in the name of medical care. To have an effective union, we must have organization. We must be able to speak in a concerted voice. The public health side of medical service is a highly organized group, its primary purpose in organization being to reach the general public or masses of people. Until quite recently, pri-

*Read before the Chattahoochee Valley Medical Association, Albany, Ga., July 14, 15, 1936.

vate medicine has not been so organized, but as it has become more and more apparent to those within the medical profession that the spotlight of public attention is being focussed upon them, the necessity for committees on public relations, medical economics, public policy, etc., has been made plain. I believe this to be a salutary move, and one which will go far toward strengthening the ties between the doctor and his patient. It will go far toward making clear to the laity the rightful position of the doctor, that of guardian of the patient's health as well as healer. It will go far toward clarifying any differences of opinion between private medicine and public health. An interested and well-informed group representing private medical practice can demand and receive the attention of public health officials when differences between them arise, and can be in a position to discuss and adjust such differences arising from either side. The result of such intelligent cooperation can only be the betterment of the health of the people which is the common end we have in view.

Inasmuch as the physician and the health department have the same goal in view, our paths must necessarily cross constantly. The private physician has much to give the health department, and the health department has services to give the physician.

One of the duties which the health department asks of the physician is the reporting of all births and signing medical certificates of deaths that occur in his practice. These statistics, when gathered into the Central Vital Statistics Bureau constitute one of the most valuable health services to the state. They are permanent state records which are indices to the welfare of the people. From them we are able to tell those diseases which take the greatest toll of life, the areas where they are most prevalent; we are able to analyze the effectiveness of our public health activities, and to judge of certain health trends.

The reporting of communicable diseases in his practice is another service which the health department asks of the physician. This is the only adequate way we have of locating such cases. It is the way in which the health department discovers the presence of epidemic disease.

In respect to the immunization program of a health department, I believe that wherever the private physicians in a community wish to carry out a standard, preventive program for that community, they should be allowed and encouraged to do so. It frequently happens that such an immunizing program is not or cannot be carried out by the private physician, in which case it becomes the public duty of the health department to do so. Epidemics of diphtheria and smallpox can be prevented only when the majority of a non-immune population has been immunized.

Tuberculosis and venereal disease are logical fields for the public health department. An individual case of tuberculosis is a source of infection to other persons in the community. It is not only a case for treatment but all contacts with the case must be discovered and preventive methods inaugurated. It is a case not only of individual health, but community health. The physician can cooperate with the health authorities by prompt reporting of a case of tuberculosis. The health department can in turn offer the physician laboratory facilities for the diagnosis of the case and, if possible, clinic service where the suspected case of tuberculosis may come at the suggestion of the private physician for diagnosis. The same applies to the venereal diseases.

Child health and maternal welfare are problems which come within the field of both private medicine and public health. It is the duty of the health department to see that the general population is informed as to the necessity for prenatal care, and the necessity for guarding the health of the child of pre-school age. I believe that it lies distinctly within the field of the private physician to perform the clinical duties of this phase of preventive medicine. This is one of the most vital problems facing us today, and the solving of it must come about through an arrangement which will be satisfactory to physician and public health officer, and which will work toward the best interests of the people.

Medical inspection of school children is a function of the health department. The routine should consist of examination for disease and physical defects, and advising with parents as to the necessity for consulting the family physician for the correction of such defects.

I wish to repeat that the answer to the threat of "State Medicine" lies in the friendly and intelligent understanding between the private physician and the public health official. It is the primary duty of the health officer to observe the rules of his duty as laid down by the law and also to observe the unwritten but equally vital

duty of cooperation with his colleagues of the medical profession. In so doing he is obeying the highest mandate of his profession and performing the greatest service for the general good.

In closing I desire to sound a note of warning that is giving much concern to health officers throughout this country. There is a grave danger of health departments being taken over, in fact if not in name, by laymen, and to be run with little regard to the rights of the medical profession. Such a course will be a disaster because only a properly trained physician has the background and the fundamental knowledge to deal with the prevention of the spread of diseases in the proper manner. Very frequently well-meaning laymen run aground when they undertake to dabble in epidemiological affairs. They are strictly honorable and mean well but they simply do not know and are not supposed to know. I do not mean to criticize these well-meaning people who are assuming this, the responsibility that belongs to health departments, I am simply stating a fact. No matter how the layman studies these questions his knowledge is bound to be superficial unless he is grounded with a thorough medical education and, in my opinion, has practiced medicine sufficiently to know the personal side of what he is dealing with. Therefore, a properly organized, well-developed, established and operated County Health Department is an asset to the physicians practicing in any city or town and any county and, of course, in any state, and if these Health Departments are manned by physicians of fine type this will do more to safeguard the legitimate interest of the medical profession and to prevent "State Medicine" than any other one thing.

THE DIAGNOSIS OF PULMONARY TUBERCULOSIS IN ITS PRE-CLINICAL AND EARLY CLINICAL STAGES*

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Philadelphia.

During the past fifty years the death rate from tuberculosis has decreased from more than 400 per hundred-thousand to less than 80 per hundred-thousand. This decrease is due to a number of factors, some of which are non-specific and others of which apply directly to the disease. Non-specific factors include a higher standard of living, shorter working hours and improved hygienic conditions. The specific factors are at least partially a result of the educational campaign of the National Tuberculosis Association and local anti-tuberculosis organizations which have informed the public of well-known facts about tuberculosis. These include the recognition of tuberculosis as a contagious disease that passes from one person to another, the necessity for early and accurate diagnosis and the value of isolation and prophylactic care in preventing spread of disease. The campaign for adequate sanatorium facilities, for proper ventilation in homes and elsewhere and for reporting tuberculosis as a contagious disease have all played a part in the improved conditions that are found today. Tuberculosis, however, is still the leading cause of death between the ages of 15 and 45 years. It is a major public health problem that can be solved by the application of the information that we now have. It is necessary therefore, to continue to apply all the means that have been of value in the past and also to utilize our knowledge of case finding in an effort to reduce the disease to the vanishing point. The expense entailed by the application of case finding methods is justified in my opinion by the success that has already been obtained.

Case finding is the diagnosis of tuberculosis in its early clinical and pre-clinical stages. There are two types of case finding in use today. One of these is the dispensary method, that is, the examination and supervision in special "chest" clinics of those who are in contact with known tuberculosis. The second is the survey method which attempts to discover in an unselected group, those who have evidence of the disease in a latent form that has not yet produced recognizable ill health.

I will first of all describe the survey method and the various procedures that are employed in its application. The survey method is applicable to groups such as high school, college and university students, to nurses and to industrial employees. It is customary to first employ the tuberculin test in order to determine those who have been infected by tuberculosis. This test depends upon the fact that within a few weeks after a person is infected by tubercle bacilli, he acquires a new property,

*Read before the Annual Conference of the Florida Tuberculosis and Health Association, Tampa, March 30-31, 1936.

namely sensitivity to tuberculin so that whereas previously the injection of tuberculin into the skin caused no reaction, it now produces an inflammatory wheal at the site of inoculation. This positive reaction consists of an area of redness and swelling which is measured by the doctor or nurse applying the test and graded as 1, 2, 3 or 4 plus and is to some extent a measure of infection with tuberculosis and to some extent a measure of resistance. There are various forms of tuberculin all of which are products of the tubercle bacillus. The most recently prepared form is known as Purified Protein Derivative and has a standard potency which does not decrease with time as long as the tuberculo-protein is kept in tablet form. The best method of application of the test is the injection of a definite quantity of this material into the skin of the forearm. This is the intracutaneous or Mantoux method of giving the test.

As I have already said, a positive reaction means that the individual has been infected by tubercle bacilli unless he has been vaccinated with killed or avirulent tubercle bacilli which may produce a positive reaction by artificial means. A negative reaction usually means that infection has not taken place. Occasionally, however, the reaction is negative in spite of past infection. The more important exceptions are as follows. In certain acute forms of tuberculosis such as tuberculous meningitis and miliary tuberculosis, a negative reaction may occur. The reaction is also slight or may be absent in the terminal stages of far advanced chronic tuberculosis. It may be absent during and following the exanthematous diseases such as measles and scarlet fever, and finally the reaction may die out after a period of months or years if the original infection fails to cause a significant lesion and reinfection does not occur. In the survey method, these false negative reactions play no practical part since sick people are not included in the groups that are examined.

X-ray examination is the second procedure that is used in group examinations. Occasionally fluoroscopic examination is given to all the members of a group without the use of the tuberculin test and films are made of the individuals in whom an abnormality is suspected. More commonly x-ray examination, usually the taking of x-ray films, is made only of the tuberculin positive members of the group. Interpretation of x-ray films in this group survey method should be done by an expert since we are looking for comparatively trivial changes that have not produced ill health as well as the more advanced infiltrations that may be present. In children of elementary school age, important lesions comprise pulmonary nodules, non-apical infiltrations and lymph node disease. In children of high school age and in young adults, apical tuberculosis is the significant lesion that is sought.

Following the tuberculin test and x-ray examination, the application of clinical procedures gives additional information. These procedures include careful physical examination of the chest, careful temperature records, sedimentation test, sputum examination and history of contact with tuberculosis. When a significant latent lesion is found the most important single consideration in treatment is the avoidance of further contact with sputum positive tuberculosis. An altered regime eliminating strenuous work and exercise, supervision of diet and increased hours of rest should be instituted in the less severe cases and sanatorium care should be given to those individuals who exhibit the more serious and advanced latent lesions that appear likely to progress to clinical disease. In our experience, cases that show evidence of toxemia such as fever or abnormal sedimentation rate, and those with physical signs, always belong to the group requiring sanatorium care.

The second method of case finding may be called the dispensary method. This consists in the examination of individuals with symptoms suggesting tuberculosis and the institution of prophylactic care and treatment when a diagnosis is made. It is among the contacts of sputum positive tuberculosis that new cases of tuberculosis are most likely to be found. Here the tuberculin test is an index of the infection of other members of the household. X-ray examination is again used to determine the presence of a lesion and to define its extent and characteristics. Members of households in which clinical tuberculosis exists should have periodic examinations with x-ray examination at appropriate intervals. The most serious lesions of the childhood type occur in infancy. It is inadvisable for children less than one year of age to live in the same household with an individual with sputum positive tuberculosis. At this age the use of prophylactic vaccination against tuberculosis has been shown to be of considerable value. This vaccination is done with a form of the

bovine tubercle bacillus known as Bacillus Calmette-Guerin which has been proven to be avirulent. During the first ten days of life the organism can be administered by mouth as the intestinal tract is permeable. After ten days of life the organism is administered intracutaneously.

The susceptibility to tuberculosis varies according to race, age and sex. In the white race, infancy and adolescence are the ages when significant lesions are most likely to appear while significant lesions are rarely found between two and twelve years of age even in those who are in known contact with tuberculosis. This is an important consideration in selecting the groups in which case finding methods should be employed. During high school years, girls exhibit apical lesions about twice as frequently as boys, and in girls these lesions begin to make their appearance at an earlier age corresponding to the earlier development of puberty. In the colored race infancy and adolescence are still the most dangerous periods but serious lesions may be discovered at all ages. In other words, the relatively high immunity found in white children of elementary school age is not found in the colored child.

It is necessary not only to emphasize the value of the tuberculin test and x-ray examination in the diagnosis of tuberculosis in the early clinical and pre-clinical stages, but it is also necessary to emphasize their value in excluding this diagnosis. Some years ago in Philadelphia there were special classes in the schools for children who were considered to have or to be threatened with tuberculosis. These children had been selected by various agencies and by various methods. Upon more careful examination, it was found that 33 or 29.7 per cent of 111 children in the classes failed to react to tuberculin while x-ray examination disclosed that only 18 per cent had anatomical lesions that would justify their inclusion in a group requiring prophylactic care for tuberculosis. This is an example of the necessity for the scientific application of these methods in the selection of children with preclinical and early clinical disease and our inability to select a group requiring prophylactic care by the usual clinical methods.

In conclusion let me repeat that tuberculosis case finding, resulting in the diagnosis of tuberculosis in its early clinical or pre-clinical stages, will result in a still further decrease in tuberculosis morbidity and mortality. The value of the tuberculin test will increase as the incidence of clinical tuberculosis decreases, for the presence of a positive reaction will lead to an immediate search for the source of infection and when found to the prevention of further spread of tuberculosis from this source. The child or young adult with x-ray evidence of latent or minimal tuberculous disease by avoiding continued exposure and by suitable prophylactic care can be prevented from developing sputum positive tuberculosis and spreading the disease to others.

SCHEDULE OF PROGRAM—ANNUAL CONVENTION

St. Petersburg, April 5, 6, 7, 1937.

Monday

1:30 p.m.—First General Session
2:30 p.m.—First Scientific Assembly
7:00 p.m.—First Meeting, House of Delegates

Tuesday

9:00 a.m.—Second Scientific Assembly
10:00 a.m.—Second General Session

2:00 p.m.—Third Scientific Assembly
5:00 p.m.—Second Meeting, House of Delegates

Wednesday

9:00 a.m.—Fourth Scientific Assembly
12:00 noon—Third General Session

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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VENEREAL DISEASE CONTROL

To comply with a request from Dr. Thomas Parran, Surgeon General of the United States Public Health Service, President Feaster has appointed six members of the Association to serve as a Committee on Venereal Disease Control. The membership of this committee is as follows: E. T. Sellers, Chairman, Jacksonville; J. I. Turberville, Century; R. D. Ferguson, Ocala; A. L. Mills, St. Petersburg; Louis M. Orr, Orlando; Roy J. Holmes, Miami.

Venereal disease control is one of the major problems receiving the special attention of the Surgeon General and he has requested the state medical societies to appoint committees for the purpose of cooperating with the U. S. Public Health Service and the Boards of Health in the various states. As has been repeatedly demonstrated in the work of these committees, it is essential that organized medicine be ably represented, not only to insure intelligent service to the citizens of the state but also to be ever alert to protect the interests of the members of the medical association. This committee of the Florida Medical Association was selected by President Feaster after a conference with Dr. Edward Jelks, the president-elect.

More than five hundred persons responded to a call of the Surgeon General for a three-day conference in Washington the early part of January to discuss the control of venereal diseases, especially syphilis. Those attending were representatives of the American Medical Association, state medical societies, practicing physicians, health officers, and social service workers. Consideration was given to the question of venereal disease control from the following points of view: (1) prevalence of syphilis in the United States; (2) the necessity for carrying treatment facilities to all persons of all economic strata, emphasis being placed on the fact that no desire existed on the part of public health officials to undertake the treatment of all cases of syphilis at public expense, but wherever possible patients should be treated by the family physicians in the usual manner and that the personal relationship of the patient to the physician should be maintained wherever possible; (3) the importance of early treatment and the treatment of the pregnant syphilitic woman; (4) the importance and necessity for follow-up work in certain types of cases, much follow-up work being eliminated by efficient, courteous and expeditious handling of patients on their first visit to the clinic; (5) the dual responsibility of the physician in any case of communicable disease, including venereal disease. The responsibility is for the patient and for the community.

The following is an exact quotation from the January 9, 1937, Journal of the American Medical Association:

"In all probability most indigent patients in denser population centers will need to be treated in clinics. In smaller communities and rural areas, treatment of the indigent was recommended through the offices of family physicians. The recommendations include payment of the physician on such a basis as might locally be agreed on for services rendered to indigent patients. Certain questions were raised relating to lack of uniformity of instruction in syphilology in the medical schools. The question was debated in the section on medical cooperation under the heading of "Undergraduate Education" and a resolution was adopted requesting the Surgeon General to refer the matter of undergraduate education in syphilology to the Council on Medical Education and Hospitals of the American Medical Association, and to the Association of American Medical Colleges. Stress was laid particularly on the desirability of carrying postgraduate educational efforts as well as the machinery of cooperation through the channels of organized medicine in the state and the local community."

NEW REMEDIES

The spirit to conquer, to solve unsolved problems, leads the profession on in a quest that adds one by one to the remedies and methods to relieve or to prevent disease. There is further research to perfect, then the crucible of proof, and it is thus we gain the accepted remedies.

It is our part, as physicians, to support such efforts with due care in the selection and proper caution in their use. There must be sufficient proof of merit before we discard the old entirely for the new.

A new remedy recently introduced, belonging to the chemotherapy group, called "prontosil," has been given considerable publicity during the past few months both in the public and professional press. Possibly, the use of this remedy to treat a prominent individual made it a headline for a short time. This may have overpopularized the remedy and caused some of the laity to become too optimistic about its value in the treatment of sinuses. This should be balanced by more caution by the profession. It may cause teaching and research centers to give more attention to the remedy and prove whether it be of value and possibly solve the method of its action which is not yet fully understood. Such groups can determine this with more certainty and accuracy, and the profession, in general, then can use the remedy in more confidence.

There are some reports on "prontosil" by medical centers that are encouraging, especially in the treatment of the streptococcic infection of the peritoneal cavity. The claim seems to be that its value is in treating streptococcic infections only. This makes more specific the indication for the use of the remedy. However, until the Council on Pharmacy and Chemistry of the American Medical Association has passed on this remedy it would be well to weigh its value. See the Journal of American Medical Association of January 2, page 48.

POST-GRADUATE SHORT COURSE

The Medical Post-Graduate Course will be held in Orlando this coming June. Excellent plans are under way to make this course of particular value to the practitioners in Florida. The Orange Court Hotel in Orlando is well arranged to take care of this Medical Short Course.

For further particulars write Dr. T. Z. Cason, Jacksonville, Chairman of the Committee.

PRE-CONVENTION MEETING

The pre-convention meeting of the Florida Medical Association was held in Jacksonville, Sunday, January 17, 1937, at the Windsor Hotel. The Duval County Medical Society acted as host and supplied refreshments to the doctors in attendance.

At 1:00 p. m., a general meeting was held, including officers of the Association, members of committees, councilors, and a number of members of the Association. The attendance was very good, being between 75 and 100.

President O. O. Feaster presided and called on the following officers for a few remarks: Drs. Jelks, Flipse, Spiers and Richardson. Mr. Wendell C. Heaton, chairman of the Florida Industrial Commission, sat with the officers at the speakers' table and was called upon for a statement relative to the workmen's compensation act. Mr. Heaton's talk, although short, was exceedingly interesting and he indicated his full cooperation with the medical profession.

The chairman of each committee was then called upon for a report of his committee. Among those present, making reports, were: Drs. Gilbert Osincup, Executive Committee; Leigh Robinson, Committee on Scientific Work; Julius C. Davis, Legislation and Public Policy; J. Ralston Wells, Public Relations; T. Z. Cason, Medical Postgraduate Course; F. Clifton Moor, Cancer Control; J. C. Vinson, Medical Economics; M. Jay Flipse, Tuberculosis and Public Health; Homer L. Pearson, Maternal Welfare and Child Health; and Gordon Ira, Advisory to Woman's Auxiliary.

Doctor Feaster then called on Dr. W. McL. Shaw, chairman of the Council, who asked the twelve councilors for their reports. Dr. J. S. Turberville read a report for the First District; Dr. T. M. Rivers for the Ninth District; Dr. Shaw his report for the Fifth District and also he read the reports of Dr. Hugh West for the Sixth District, Dr. M. D. Council for the Tenth District and Dr. F. K. Herpel for the Eleventh District. Doctor Shaw announced that the missing reports would be turned in at an early date for publication in the Journal and that he, as chairman of the Council, would prepare a general report to be presented at the first meeting of the House of Delegates in April.

REPORTS OF DISTRICT COUNCILORS*

FIRST DISTRICT—

J. S. Turberville, M.D. *Century*
Bay, Escambia, Holmes, Okaloosa, Santa Rosa, Walton, Washington.

Escambia County Medical Society

Escambia County Medical Society, including the doctors of Escambia and Santa Rosa Counties, has 37 members. Nine regular and two special meetings were held during the year. There were four formal papers read, and case discussions at each meeting. The society fostered the organization of The Political Health Council, composed of doctors, dentists, nurses, and druggists. By permission of the Society, a Maternal Welfare and Child Hygiene Clinic was established in the northern end of Escambia County. A committee of the Society met with committees from Mobile, Alabama, and Gulfport, Mississippi, and organized the Gulf Coast Clinical Society. This is to meet at such times as will not interfere with or detract from the meetings of the respective state associations. The general idea is not to let it grow too large.

Bay County Medical Society

Bay County Medical Society has 11 members, all living in Panama City. There were four formal papers during the year from guests. There were case discussions at all the meetings. In a personal interview, the president told me that they did not have regular meetings. I advised regular meetings, and the encouragement of formal papers and extensive discussions among themselves. The president is very wide awake. I did not meet any of the other members.

Walton-Okaloosa County Medical Society

This society has five members, had nine meetings, four papers, ten case discussions, and a luncheon at each meeting.

Washington-Holmes County Medical Society

This society was organized on December 20, 1936, with five members. Application is now being made for a charter.

I wish to acknowledge here my gratitude for the assistance of Dr. Bryans in organizing this society.

FIFTH DISTRICT—

W. McL. Shaw, M.D. *Jacksonville*
Clay, Duval, Nassau, St. Johns.

The Fifth District comprises the counties of Duval, St. Johns, Clay, and Nassau. Active medical organizations exist only in Duval and St. Johns Counties. Physicians from Clay and Nassau Counties have joined the organized medical groups of Duval and St. Johns Counties. No questions requiring action or investigation by the Councilor have been brought to his attention during the year. Harmony has prevailed throughout this District.

St. Johns County has a membership of ten, having added one new member during the year. There have been no transfers and no deaths. Nine regular scientific meetings were held during the year. This society has one hundred per cent paid up dues for 1936.

Duval County has an active membership of one hundred sixty-seven, being one of the largest societies in the state. Meetings are held on the first Tuesday night of each month. Two members were transferred to other societies during the year, one honored member was lost by death, namely, Dr. H. H. Harris. Thirteen new members were admitted by election.

The society held nine regular scientific meetings during the year. Guest speakers from out of the state included Dr. Arnold Bargen, of the Mayo Clinic, who presented an address on Dysentery. The society was also honored by a visit from Dr. William Allen Pusey, who addressed the Society on Organized Medicine. Dr. Pusey is a past president of the American Medical Association. The society is enjoying a healthy growth and the average attendance at the regular monthly meetings has improved during the year. Duval County also reports dues one hundred per cent paid up for 1936, which gives the entire Fifth District a one hundred per cent paid up record.

SIXTH DISTRICT—

Hugh West, M.D. *DeLand*
Flagler, Putnam, Volusia.

Volusia County Medical Society

Regular meetings are held monthly; the meetings are unusually interesting and lively, discussions being held. At the present time, concentrated efforts are being made toward getting evidence against a notorious outlaw physician and abortionist. The Society has adopted a resolution requiring members to get an affidavit from all criminal abortion patients, stating who induced the abortion, before assuming any responsibility in the case.

This Society has an average of 80% of membership attendance at meetings. Several new members have been added to the roll during the past year.

*Read before the Pre-Convention Meeting, Jacksonville, January 17, 1937.

SEVENTH DISTRICT—
J. C. KNIGHT, M.D.*Plant City*
Hillsborough, Manatee, Pinellas, Sarasota.

HILLSBOROUGH COUNTY MEDICAL SOCIETY

The first part of 1936 was taken up with many guest speakers, notably, Drs. Julian A. Moore and A. B. Craddock of Asheville, N. C., Dr. J. A. Bargen of the Mayo Clinic, Dr. William E. Lower of the Cleveland Clinic and Dr. H. Hamilton Cooke of Miami. In February a banquet was given Dr. James S. McLester, president of the American Medical Association and Dr. Herbert L. Bryans, president of the Florida Medical Association.

The last part of the year was taken up with the placing of the society on a firm legal basis and a higher ethical plane by the acceptance of a new constitution and by-laws.

The society lost two valuable members through the deaths of Drs. J. J. Saxton and G. E. W. Hardy.

Before the society was reorganized, it had 119 members with 7 new members, 2 being transfers. The year closed with a membership of 98, one of which is an honorary membership.

The Hillsborough County Medical Society endorsed the new County Health Unit set-up and a committee was appointed in an advisory capacity to the director of the local county unit.

MANATEE AND SARASOTA COUNTY MEDICAL SOCIETIES

The Manatee County Medical Society and the Sarasota County Medical Society hold joint meetings, each society being responsible for the program every other month. The meetings are informal and a number of prominent doctors have been guests. No meetings are held during the summer season. The Manatee County Medical Society has a membership of 11 and the Sarasota County Medical Society a membership of 18.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society has a membership of 89, including 5 new members. This society meets twice each month for dinner—on the first and third Fridays. The average attendance is about 50, with an average of 5 guests at the meetings.

NINTH DISTRICT—
THOMAS M. RIVERS, M.D.*Kissimmee*
Brevard, Lake, Orange, Osceola, Seminole.

Your councilor has little to report. There have been no important events come up in any of the counties of this district which have been brought to my notice.

At the regular November meeting of the Seminole County Medical Society I was with them through invitation. I am happy to report that I found a well organized group working in harmony for the best interests of organized medicine in their community.

Orange County Medical Society, which includes Osceola, as well as Orange County, is prosperous and is trying to hold itself aloof from all kinds of irregularities which are ever trying to invade the ranks of organized medicine.

I have not visited the societies of Brevard and Lake Counties, but have tried to keep in touch with the work in these counties and thus far have not heard of any irregularities or difficulties in their operations. One member of the Brevard County Society is from Osceola County.

In the face of the socialistic tendencies of the times, I am glad to report that organized medicine is yet on a firm basis in this district.

TENTH DISTRICT—
M. D. COUNCIL, M.D.*Ft. Pierce*
Indian River, Martin, Okeechobee, St. Lucie.

As Councilor for the Tenth District, I wish to submit a brief report of the St. Lucie-Okeechobee-Indian River-Martin County Medical Society.

This society, of which Dr. M. D. Council is President, Dr. H. D. Clark, Vice-President, and Dr. G. C. Hardie, Secretary-Treasurer, has had fairly regularly attended monthly meetings. By removal the society lost members from Okeechobee County but additions in Ft. Pierce have given the society a membership of thirteen with 100% paid up dues for 1936.

The society has been fortunate in having had Dr. A. J. Logie of the Tuberculosis Bureau of the State Board of Health, as guest speaker on November 26th. The society also entertained the East Coast Medical Society on November 13th and 14th with splendid attendance and program.

Interest in the Society is good.

ELEVENTH DISTRICT—
F. K. HERPEL, M.D.*W. Palm Beach*
Broward, Palm Beach.

Your Councilor for the Eleventh District regrets to report that he has not formally visited the Broward County Medical Society so far in his term, but hopes to do so before the end of the society year.

No matters requiring action or investigation by the Councilor have been brought to his attention during the year so far. So far as he can

ascertain, harmony has prevailed throughout this councilor district. This is a tribute to the splendid officers who have headed these societies this year. The newly elected officers will, I am sure, take hold and carry on in the same manner.

In Palm Beach County, with but few exceptions, the qualified physicians practicing in the county belong to the Palm Beach County Medical Society. In a few instances otherwise qualified men have not been elected to membership because of unethical practices and affiliations. Several applications from physicians recently located in the county are before the society for their action, and we anticipate a number of additional members in the near future.

A notorious naturopath, who has repeatedly and flagrantly infringed on the legitimate practice of medicine on the strength of a fraudulently obtained diploma from a quasi-medical institution, has finally left the county for parts unknown. His nefarious activities over a period of almost ten years left little to the imagination. A more rigid interpretation of the rights of irregular practitioners seems mandatory if such experiences are not to be repeated throughout the state.

It was our pleasure to have the President of the Florida Medical Association meet with the physicians of this county on two occasions during this year. Throughout this district there is a feeling that we have been well and ably represented by our state officers during these past months, and that our interests are their interests where those interests tend to improve the practice of medicine throughout this county and the state of Florida.

MALPRACTICE INSURANCE

Several members have inquired of the Business Office as to whether physicians' liability insurance policies cover assistants. In response to this question, we have received the following letter from the United States Fidelity and Guaranty Company:

"Re: Group Policy PL-535, Florida Medical Association. Assured is covered in claim against Assured for act of Assistant when Assistant was employed subsequent to original application and no premium has been charged because Assured failed to notify Company of Assistant's employment. Company will require payment of back premiums for such employment when disclosed. Members when insured should be instructed to notify Company of any subsequent change in medical status including employment or discharge of Assistants during policy term and renewal terms."

MEMBERSHIP, 1936

On the following pages appear a complete roster of members of the Florida Medical Association who paid Association dues for the calendar year 1936. Following an established custom, the membership roster is always published in the February Journal.

For the convenience of our members, it is planned to run reprints of this roster so that they can be used independently of the February Journal. It is hoped that these reprints will be carefully filed by all of our members for reference.

Nineteen hundred thirty-six is the record year of the Association in that it represents the largest number of paid members in the history of the Association. There were 1,120 members who paid State Association dues for that year. The previous record was for 1927 when the paid membership reached 1,106.

The component societies of the state are entirely responsible for the splendid showing of the State Association in this respect. During the year, 28 of our 32 component societies had a 100% record of paid members. This is, indeed, very encouraging. The united strength of active component societies makes the State Association a powerful organization. The following societies are listed in the 100% paid group:

Alachua County Medical Society.
Bay County Medical Society.
Brevard County Medical Society.
Broward County Medical Society.
Columbia County Medical Society.
Dade County Medical Society.
Duval County Medical Society.
Jackson County Medical Society.
Lake County Medical Society.
Lee County Medical Society.
Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society.
Madison County Medical Society.
Manatee County Medical Society.
Marion County Medical Society.
Monroe County Medical Society.
Orange County Medical Society.
Pasco-Hernando-Citrus County Medical Society.
Pinellas County Medical Society.
Polk County Medical Society.
Putnam County Medical Society.
St. Johns County Medical Society.
St. Lucie-Okeechobee-Indian River-Martin County Medical Society.
Sarasota County Medical Society.
Seminole County Medical Society.
Sumter County Medical Society.
Taylor County Medical Society.
Volusia County Medical Society.
Walton-Okaloosa County Medical Society.

MEMBERSHIP ROSTER
FLORIDA MEDICAL ASSOCIATION
CALENDAR YEAR 1936

ALACHUA COUNTY MEDICAL SOCIETY (DISTRICT "B")

Andrews, Edwin H., President,
208 W. Mechanic St....Gainesville
Summitt, R. E., Vice-President,
335 W. University Ave..Gainesville
Merchant, Harry M., Sec'y-Treasurer,
124 E. University Ave...Gainesville
Ahmann, Chester F.,
University of Florida...Gainesville
Anderson, James M.....Cross City
Cobb, Alva Thos., Jr.,
Fla. Farm Colony.....Gainesville
Dailey, I. A. Micanopy
Dell, J. Maxey, Sr.,
333 W. Main St. So.....Gainesville
Dell, J. Maxey, Jr.,
333 W. Main St., So....Gainesville
DePass, Matthew H.,
E. University Ave.....Gainesville
Elmore, W. T.,
Baird Bldg. Gainesville
*Hodges, James H.,
234 E. Main St.....Gainesville
King, Seeber Lake Butler
Lassiter, Wilburn Gainesville
Maines, John E., Jr.,
331½ W. University Ave.,
Gainesville
Maines, John E., Sr. Lake Butler
Mathers, Fred,
University Infirmary ...Gainesville
Preston, H. F. Melrose
Raborn, John D.,
P. O. Box 145 Trenton
Smith, DeWitt T.,
Tucker Bldg. Gainesville
Snow, Thomas A.,
103 E. University Ave...Gainesville
Summerlin, J. L.,
1 Baird Bldg. Gainesville
Thomas, William C.....Gainesville
Tillman, Geo. Clarence,
505 W. University Ave., Gainesville
Willis, J. M. Williston
Young, Wm. Clement Chiefland

BAY COUNTY MEDICAL SOCIETY (DISTRICT "A")

Roberts, William C., President,
Panama City
Nixon, James Montgomery, Vice-Pres.,
Panama City
Miller, Allen H., Sec'y-Treas., Millville
Adams, D. M., Jr.....Panama City
Bird, Terry,
Company 1416 CCC.....Chipley
Blackshear, W. J. Panama City
Fraser, Donald Scott.....Panama City
Lingo, M. J. Panama City
Lisenby, Amsie H.,
526 Harrison Ave....Panama City
Middlebrooks, Wm. E. Panama City
Perkins, Herman Panama City
Whitfield, J. M.....Panama City

BREVARD COUNTY MEDICAL SOCIETY (DISTRICT "E")

Bean, I. F., President.....Melbourne
Counts, N. T., Vice-President....Cocoa
Schlernitzauer, Bob, Secy-Treasurer,
Rockledge
Chunn, J. D. St. Cloud
Creel, W. J. Eau Gallie
Hay, Isaac M. Melbourne
Kenaston, T. C. Cocoa
Page, Walter C.,
317 Delannoy Ave.....Cocoa
Potthoff, E. W. Titusville

BROWARD COUNTY MEDICAL SOCIETY (DISTRICT "F")

Hendricks, Elliott M., President,
314 Sweet Bldg.....Ft. Lauderdale
Stovall, R. H., Vice-President,
First Natl. Bank Bldg.,
Ft. Lauderdale
Blount, Robt. E., Sec'y-Treas.,
360 S.E. 26th Ave...Ft. Lauderdale
Brown, Oliver C.,
915 Sweet Bldg. Ft. Lauderdale
Brunson, Francis A. Hollywood
Carter, Donald E.,
915 First Natl. Bank Bldg.,
Ft. Lauderdale
Cohn, Jess V.,
226 Bank Bldg. Hollywood
Conner, A. B.,
Sweet Bldg.....Ft. Lauderdale
Darrow, Anna A.,
310 S.E. 7th St. Ft. Lauderdale
Denniston, Frank,
616 Sweet Bldg. Ft. Lauderdale
Elliston, Leroy B.,
814 Sweet Bldg. Ft. Lauderdale
Elliston, Robt. L.,
810 Sweet Bldg. Ft. Lauderdale
Farringer, Robt. H.,
1666 Hollywood Blvd....Hollywood
Hamner, Geo. P.,
102 20th Ave., S.....Hollywood
Harriss, R. R.,
Natl. Bk. Bldg. Hollywood
McClellan, George S.....Pompano
McLaury, Elbert,
214-20 First Natl. Bk. Bldg.,
Hollywood
Mayhew, Royal H.,
Box 3237 Ft. Lauderdale
Peavy, Henry J.,
First Natl. Bank Bldg.,
Ft. Lauderdale
Robinson, Leigh F.,
715 Sweet Bldg. Ft. Lauderdale
Roper, Luther E.,
2011 Hollywood Blvd....Hollywood
Skiff, Francis S.,
303 First Natl. Bk. Bldg.,
Ft. Lauderdale
Sory, Curtis H.,
616 Sweet Bldg. Ft. Lauderdale
Stanford, John A.....Ft. Lauderdale

COLUMBIA COUNTY MEDICAL SOCIETY (DISTRICT "B")

§Anderson, L. M., President,
Box 707.....Lake City
Harkness, Robert B., Vice-President,
605 E. Duval St.....Lake City
Bates, Thomas H., Sec'y-Treasurer,
Blanche Hotel Annex.....Lake City
Anderson, J. G. Lake City
§Anderson, Thomas S.,
Box 127 Live Oak
Brown, Edgar F.....Lake City
Ives, Washington M.,
132 N. Marion St. Lake City
Nichols, Wm. S. Lake City
Rose, Joseph,
1345 Talbot St. Jacksonville
Spearman, Mathew W.,
Morrison Bldg.....Lake City

DADE COUNTY MEDICAL SOCIETY (DISTRICT "F")

Hall, John E., President,
Box 2722 Miami
Walker, Harrison A., Vice-President,
541 Lincoln Road Miami Beach
Threlkeld, Major E., Secretary,
Congress Bldg. Miami
Barge Hubert A., Treasurer,
301-2 Olympia Bldg.....Miami
Adkins, E. H.,
835 Lincoln Road.....Miami Beach
Agos, Isadore H.,
903 Huntington Bldg.....Miami
Alderson, S. P.,
427 Ingraham Bldg. Miami
Alexander, Julius,
301 Huntington Bldg. Miami
Allen, Omer F.,
711 Huntington Bldg.....Miami
Amerise, A. Daniel,
Coral Gables Clinic....Coral Gables
Arango, Roger J.,
Ingraham Bldg. Miami
Aronovitz, Samuel,
705 Huntington Bldg.....Miami
Baker, Juel M.,
630 Seybold Bldg.....Miami
Baker, L. A.,
570 W. Flagler St.....Miami
Barfield, J. O.,
312 N. W. Third Ave.....Miami
Barge, W. J.,
442-3 Ingraham Bldg.....Miami
Batten, Glenn D.,
1st Natl. Bk. Bldg..Jackson, Tenn.
Bible, C. J.,
1203 W. Flagler St.....Miami
Black, Nelson M.,
703 Huntington Bldg.....Miami
Boughton, Herman,
441 Washington Ave...Miami Beach
Bowen, Carroll T.,
2610 S.W. 8th St. Miami
Bowman, Robert N.,
Bastain Bldg. Miami Beach
Browne, Van M. Hialeah
Brunner, E. C.,
503 Olympia Bldg.....Miami
Bullard, Clifton P.,
406 N. E. 2nd Ave.....Miami
Burch, R. N.,
1774 S.W. 8th St. Miami
Chambers, Silas E.,
409 Huntington Bldg.....Miami
Chandler, G. E.,
Huntington Bldg.....Miami
Cleghorn, Charles D.,
1109 Huntington Bldg.....Miami
Cleveland, Jack Q.,
LeBlond Bldg. Coral Gables
Conger, George D.,
1600 N. W. 36th St.....Miami
Cooke, H. Hamilton,
905 Huntington Bldg. Miami
Coplan, M. M.,
601 Huntington Bldg.....Miami
Couric, Edmonson S.,
P. O. Box 265, Lemon City..Miami
Davis, H. Frank,
1009 Huntington Bldg.....Miami
Day, George H.,
600 W. Flagler St.....Miami
DeBoe, Michael P.,
414 1st Natl. Bk. Bldg.....Miami
Deederer, Carleton,
139 S.E. 3rd St. Miami
Dees, John,
Ingraham Bldg.....Miami
DeVore, Louise,
809 Huntington Bldg.....Miami
Dobrin, Max,
1023 Lenox Ave. Miami Beach
Dodge, Percy L.,
812 Huntington Bldg.....Miami
Dowling, Otto S.,
Lincoln Medical Arts Bldg.,
Miami Beach
Dunaway, Carl E.,
1209 Huntington Bldg.....Miami
Dunne, H. E.,
2985 S. W. 15th St.....Miami
DuPuis, J. G.,
6043 N.E. 2nd Ave.....Miami
Elder, Samuel F.,
Huntington Bldg.....Miami
Elgin, Lee W.,
541 Lincoln Road.....Miami Beach
Ellis, Wm. H.,
800 N.E. 2nd Ave. Miami
Eskew, Don C.,
800 N.E. 2nd Ave. Miami
Faver, R. Marshall,
127 N.E. 5th St. Miami
Feld, Nathan,
1260 Collins Ave.....Miami Beach
Fernandez, Francisco M.,
Ingraham Bldg. Miami
Fitzgerald, Willard L.,
422-23 Ingraham Bldg.....Miami
Flipse, M. Jay,
305 Huntington Bldg. Miami
Fox, H. H.,
Box 2523 Miami
Franklin, Grover C.,
P. O. Box 75, Coconut Grove, Miami
Freidus, Elias,
933 Lincoln Road Miami Beach
French, Elmo D.,
603 Huntington Bldg.....Miami

* Deceased. † Honorary Member. § Life Member.

Frobisher, Hamilton B.,
809 Douglas Entrance, Coral Gables
Gammage, Tom Rogers,
221 N. E. 5th St.....Miami
Garrard, Hollis F.,
337 Lincoln Rd. Miami Beach
Ghertler, Max,
Box 1762 Riverside Station, Miami
Goodson, W. M.,
800 N.E. 2nd Ave. Miami
Gowdy, Francis A.,
417 Orange Ave. Ft. Pierce
Gowdy, Ralph A.,
541 Lincoln Road Miami Beach
Graves, J. Raymond,
709 Huntington Bldg. Miami
Grimes, D. H.,
P. O. Box 377.....South Miami
Haggard, William A.,
1101 Huntington Bldg.....Miami
Hall, E. J.,
201 Venetian Bldg.....Miami
Hall, Young L., Jr.,
200 Venetian Arcade Miami
Hanna, Fouad H.,
1299 Brickell Ave.....Miami
Hardie, Dan., Jr.,
1104 N.W. 1st St. Miami
Harris, David W.,
403 Huntington Bldg.....Miami
Harris, Robert M.,
1010 Huntington Bldg.....Miami
Hartman, M. D. Homestead
Hatch, Ernest B.,
71 N. E. 11th St.....Miami
Heck, Maurice E.,
125 N. E. 3rd St.,.....Miami
Hewlett, Frank W.,
202 LeBlond Bldg. Coral Gables
Hobbs, Laura Mae,
653 S. W. 2nd St.....Miami
Hodsdon, Benj. F.,
P. O. Box 923.....Miami
Hodsdon, L. A.,
418-20 Security Bldg.....Miami
Holmes, Albert G. H.,
867 N.E. 76th St.....Miami
Holmes, Roy J.,
501 Huntington Bldg. Miami
Hotchkiss, W. T.,
541 Lincoln Road.....Miami Beach
Howell, R. Spencer,
714-16 Security Bldg.....Miami
Hutson, Thomas W.,
309 Huntington Bldg.....Miami
Ingersoll, J. M.,
1700 S. Bayshore Lane.....Miami
Jeffrey, S. L.,
4022 Douglas Road.....Miami
Jenkins, Leslie M.,
712 Huntington Bldg.....Miami
Jenkins, Paul K.,
541 Lincoln Road....Miami Beach
Jones, Allan,
541 Lincoln Road Miami Beach
Jones, Walter C., Jr.,
802 Huntington Bldg. Miami
Kay, Milton B.,
330 Ingraham Bldg. Miami
Keeler, Frank L.,
1106 Huntington Bldg.....Miami
Kells, Paul,
429 Ingraham Bldg.....Miami
Kennon, Charles L.,
411 Huntington Bldg.....Miami
Kinsey, E. T.,
320 N.W. 7th Ave.....Miami
Kirsch, Maxwell D.,
408 Huntington Bldg. Miami
Kitchens, F. E.,
2506 Ponce de Leon Blvd.,
Coral Gables
Lamar, C. P.,
342 Ingraham Bldg. Miami
Lanier, W. T.,
335 Ingraham Bldg. Miami
Laymon, R. L.,
300 Venetian Arcade Bldg....Miami
Leavitt, H. A.,
127 N. E. 5th St. Miami
Lefholz, Rothwell,
1009 Huntington Bldg.....Miami
Levin, Alfred G.,
Jackson Memorial Hospital, Miami
Lewis, Taylor,
302 Congress Bldg.....Miami
Light, S. D. W.,
Ingraham Bldg.....Miami
Lithgow, William D.,
2200 Biscayne Blvd Miami
Litterer, A. B.,
309 Huntington Bldg.....Miami
Lott, Young C.,
144 N. E. 2nd Ave.....Miami
Lovejoy, M. A.,
417-20 Sweet Bldg...Ft. Lauderdale
Lowe, Eugene C.,
258 N. E. 21st St.....Miami
Lucinian, Joseph H.,
403 Huntington Bldg.....Miami
Lustgarten, A.,
1527 Washington Ave., Miami Beach
Lyell, R. O.,
310 Huntington Bldg.....Miami
McClamroch, James M.,
410 Ingraham Bldg. Miami
McDonald, John T.,
312 Huntington Bldg.....Miami
MacDonell, Geo. N.,
P. O. Box 1851.....Miami
McGunagle, J. E.,
1885 W. Flagler St.....Miami
McKenzie, E. N.,
335 Ingraham Bldg.....Miami
McKenzie, Jack A.,
Huntington Bldg. Miami
McKibben, Wm. W.,
316-18 Ingraham Bldg.....Miami
McShane, James K.,
307 Ingraham Bldg.....Miami
Manson, Plumer J.,
277 N.E. 82nd St. Miami
Marsh, Lucille J.,
812 Huntington Bldg. Miami
Martin, M. C.,
1774 S.W. 8th St. Miami
Maxwell, Eugene B.,
337 Lincoln Road.....Miami Beach
Medlin, Willard B.,
502 Security Bldg.....Miami
Mentzger, Claude,
2701 Biscayne Blvd. Miami
Milton, J. D.,
503 Huntington Bldg. Miami
Moore, T. Earl,
Menninger Sanatorium,
Topeka, Kans.
Morrow, Frank R.,
1006 Huntington Bldg. Miami
Mosley, R. Sam,
Seybold Bldg. Miami
Nichol, E. Sterling,
305 Huntington Bldg.....Miami
Nugent, J. J.,
10 E. Rio Alta Island, Miami Beach
O'Quinn, Leon H. Hialeah
Otto, T. O.,
704 Huntington Bldg.....Miami
Owens, Duncan,
337 Lincoln Road.....Miami Beach
Palmer, Bascom H.,
502 Huntington Bldg.....Miami
Panettiere, Cayetano,
P. O. Box 227.....Miami Beach
Paulk, George A.,
202 Venetian Bldg.....Miami
Payton, Frazier J.,
Allison Hospital Miami Beach
Pearson, Colquitt,
1107 Huntington Bldg.....Miami
Pearson, Homer L., Jr.,
1108 Huntington Bldg.....Miami
Pearson, John R.,
502 Olympia Bldg.....Miami
Pearson, Nelson T.,
1109 Huntington Bldg.....Miami
Pearson, Rufus J.,
Huntington Bldg.....Miami
Pepper, Max,
719 Seybold Bldg.....Miami
Perdue, Jean,
1213 Lincoln Road....Miami Beach
Perdue, John R.,
Ingraham Bldg. Miami
Perry, C. Larimore,
509 Huntington Bldg.....Miami
Peters, Edgar,
505 Olympia Bldg.....Miami
Phillips, Kenneth,
610 Huntington Bldg.....Miami
Pollock, Benjamin,
952 Collins Ave. Miami Beach
Preston, E.,
St. Francis Hospital..Miami Beach
Putnam, J. H.,
305 Huntington Bldg.....Miami
Quillian, Warren,
Coral Gables Clinic....Coral Gables
Raap, Gerard,
908 Huntington Bldg.....Miami
Reiss, George L.,
Lincoln Road Miami Beach
Rentz, L. S.....Coconut Grove, Miami
Rentz, William C.,
3532 N. W. 17th Ave.....Miami
Repass, Robt. E.,
835 Lincoln Road Miami Beach
Richardson, James C.,
509 Olympia Bldg. Miami
Richardson, John R.,
Lincoln Road.....Miami Beach
Rinaman, James,
6043 N. E. 2nd Ave.....Miami
Roberts, Sam J.,
347-8 Ingraham Bldg. Miami
Roche, Chas. F.,
P. O. Box 483.....Miami Beach
Rogers, Hunter B.,
27 N. W. 12th Ave.....Miami
Roth, Edward,
904 Collins Ave. Miami Beach
Ryan, Harold A.,
Aladdin Medical Arts Bldg.,
Miami Beach
Salley, S. Marion,
440 Ingraham Bldg. Miami
Sams, Wiley M.,
312 Ingraham Bldg.....Miami
Sayles, Chas. F.,
311 N. W. Third St.....Miami
Scarbrough, C. A.,
800 N.E. 2nd Ave. Miami
Schaeffer, O. N.,
931 Catalonia Ave Coral Gables
Seeds, John B.,
544 W. Flagler St.....Miami
Shaw, E. Clay,
702 Huntington Bldg.....Miami
Shisler, J. W.,
409 Olympia Bldg. Miami
Silverman, Harry Z.,
750 Collins Ave.....Miami Beach
Skaggs, P. T.,
510 First Natl. Bk. Bldg.....Miami
Skilling, Francis C.,
401 Ingraham Bldg.....Miami
Smith, C. Kirby,
300 Ingraham Bldg. Miami
Smith, J. A. Homestead
Smith, J. W.,
1661 W. Flagler St. Miami
Smith, Marvin,
405 Huntington Bldg.....Miami
Snyder, John W.,
402 Huntington Bldg.....Miami
Spicer, Robert T.,
1409 Huntington Bldg.....Miami
Stewart, Franz,
1105 Huntington Bldg.....Miami
Stewart, J. S.,
1105 Huntington Bldg.....Miami
Stuart, J. D.,
227 N. E. 5th St.....Miami
Tallman, Maurice H.,
1401 Huntington Bldg.....Miami
Thomas, Edwin C.,
46 N. E. 5th St. Miami
Thomas, Kelly C.,
318 N. W. 1st St.....Miami
Thomas, Merrick D.,
755 N.W. 36th St. Miami
Thomson, Wm. Ross,
835 Lincoln Road.....Miami Beach
Thorne, James I.,
300 Seybold Bldg. Miami
Tower, John B.,
32 N. Krome Ave.....Homestead
Travers, Milton P.,
Ingraham Bldg. Miami
Tumlin, C. E.,
Tumlin Bldg., 800 N.E. 2nd Ave.,
Miami
Turner, John C.,
300 Ingraham Bldg. Miami
Vinson, Willie J.,
400 Ingraham Bldg.....Miami
Vogt, Ferdinand A.,
802 Huntington Bldg. Miami
Voris, Frank B.,
541 Lincoln Road Miami Beach
Walters, Arthur L.,
Lincoln Road Miami Beach
Watters, Wm. H.,
Boston-Miami Clinic,
Coconut Grove, Miami
Weiland, Arthur H.,
227 Aragon Ave.....Coral Gables
Weinkle, Barney,
302 Huntington Bldg.....Miami
Welch, P. B.,
Huntington Bldg.....Miami
Welchel, Lynn W.,
Ingraham Bldg. Miami
White, D. Ward,
1659 Washington Ave., Miami Beach
Whitten, Benj. L.,
414 1st National Bk. Bldg., Miami

* Deceased. † Honorary Member. § Life Member.

Wilson, M. C.,
809 Huntington Bldg.....Miami
Withers, G. H.,
Aladdin Med. Arts Bldg.,
Miami Beach
Wood, Arthur W.,
401 Security Bldg.....Miami
Woodard, Robert C.,
Jackson Memorial Hospital..Miami
Wright, Scheffel,
315 Ingraham Bldg.....Miami
Yarbrough, Henry C.,
127 N.E. 5th St. Miami
Youmans, Corren P.,
Veterans Hospital...St. Petersburg
Youmans, I. C.,
653 S. E. 2nd St.....Miami

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY (DISTRICT "D")

McKnight, George S., President,
Jacaranda Arcade Avon Park
Martin, Leldon W.,
Sec'y-Treasurer Sebring
Aurin, E. C. Ft. Ogden
Bevis, Henry P.....Arcadia
Boorom, Hartley E.,
37-39 S. Ridgewood Dr.....Sebring
Brewster, Guy O. Avon Park
Chandler, Isaac W.,
First Trust Bldg.....Avon Park
Eide, A. T. Lake Placid
Highsmith, G. F. Arcadia
Kayton, M. C. Wauchula
Kirkpatrick, Charles H.,
Box 454 Arcadia
McDaniel, Thomas F.....Sanford
McSwain, Gordon Henry.....Arcadia
Peacock, W. H. Wauchula
Poucher, A. A. Wauchula
Simmons, John A.....Arcadia
Simmons, S. J., Jr.....Belle Glade
Spears, Ben D. Wauchula
Touchton, W. C.....Avon Park
Weems, Howard V.,
22 Oak St. Sebring

DUVAL COUNTY MEDICAL SOCIETY (DISTRICT "C")

Shaw, W. McL., President,
St. James Bldg. Jacksonville
Morris, Kenneth A., President-elect,
237 W. Duval St.....Jacksonville
Mabry, Charles B., Vice-President,
439 St. James Bldg. ...Jacksonville
Porter, H. W., Secretary,
340 St. James Bldg....Jacksonville
Hayes, John W., Treasurer,
209 Professional Bldg., Jacksonville
Adams, George E.,
2017 Main St.....Jacksonville
Adams, Thomas S.,
612 Lynch Bldg. Jacksonville
Alford, Neil,
St. James Bldg.....Jacksonville
Arms, B. L.,
P. O. Box 353....Farmington, Me.
Baker, Robert M.,
Professional Bldg.....Jacksonville
Baumgartner, Carl J.,
406 Masonic Bldg.....Jacksonville
Bayless, W. C.,
202 St. James Bldg....Jacksonville
Beckman, George E.,
Professional Bldg.....Jacksonville
Black, J. B.,
St. James Bldg.....Jacksonville
Blackmar, Ray W.,
320 St. James Bldg....Jacksonville
Boone, James L.,
500 Professional Bldg, Jacksonville
Borland, J. L.,
University Club, 16th and
Locust Sts. Philadelphia, Pa.
Boyd, Charles W.,
111 W. Adams St. Jacksonville
Bransford, L. E.,
Professional Bldg.....Jacksonville
Brillhart, H. L.,
Graham Bldg. Jacksonville
Brink, Fritz A.,
Dist. Health Comm., Blackshear, Ga.
Brinson, P. A.....Baldwin
Brinson, W. D.....Baldwin
Broadbent, Oliver P.,
454 St. James Bldg.....Jacksonville
Brown, Alan DeWitt,
417 St. James Bldg....Jacksonville
Bryant, James M.,
303 Medical Arts Bldg., Jacksonville
Buckman, Thomas E.,
1022 Park St.....Jacksonville
Carefoot, E. I.,
Professional Bldg.....Jacksonville
Cason, Turner Z.,
2033 Riverside Ave.....Jacksonville
Chapman, Benjamin A.,
2151 Pearl St.....Jacksonville
Chilli, Joseph L.,
401 St. James Bldg. ...Jacksonville
Collins, C. C.,
1855 Laura St. Jacksonville
Copeland, Silas M.,
203 St. James Bldg.....Jacksonville
Copp, F. A.,
458 St. James Bldg....Jacksonville
Counts, H. W.,
312 Peninsular Life Bldg,
Jacksonville
Croft, George W.,
713 Greenleaf Bldg....Jacksonville
Croft, Theo. G.,
713 Greenleaf Bldg. ...Jacksonville
Cunningham, Lester W.....Mandarin
Day, Gaston,
310 W. Church St.....Jacksonville
Dean, Russell,
St. James Bldg.....Jacksonville
Drew, Horace R.,
St. James Bldg.....Jacksonville
Driskell, Simon E.,
458 St. James Bldg.....Jacksonville
Dyrenforth, Lucien Y.,
P. O. Box 2098, W. Bay Annex,
Jacksonville
Eaton, Paul,
2835 Selma St. Jacksonville
Erwin, Stanley,
1001 Lynch Bldg.....Jacksonville
Ferrara, John D.,
313 Greenleaf Bldg. ..Jacksonville
Field, Thomas S.,
712 Laura St.....Jacksonville
Fort, Frank L.,
201 Medical Arts Bldg..Jacksonville
Gammon, Julian E.,
700 Professional Bldg...Jacksonville
Goodale, Banks H.,
St. James Bldg.....Jacksonville
Gorman, John M.,
Peninsular Life Bldg., Jacksonville
Greene, Ralph N.,
210 LeBlond Bldg.....Coral Gables
Hanson, Henry.
Care Consulado General,
de EE. UU. Guayaquil Ecuador
Hanson, Karl B.,
357 St. James Bldg....Jacksonville
Harrell, D. E.,
St. James Bldg.....Jacksonville
Harrell, O. E.,
St. James Bldg.....Jacksonville
Harris, W. G.,
St. James Bldg.....Jacksonville
Hartman, James H.,
546 Lomax St.....Jacksonville
Henley, Charles F.,
412 St. James Bldg. ...Jacksonville
Henson, Graham E.,
201 St. James Bldg.....Jacksonville
Holden, Gerry R.,
Medical Arts Bldg.....Jacksonville
Holloway, Luther W.,
359 St. James Bldg....Jacksonville
Horne, Hendley F.,
325 W. Duval St.....Jacksonville
Hughes, V. A.,
302 St. James Bldg....Jacksonville
Humphreys, David G.....Fernandina
Ira, Gordon H.,
451 St. James Bldg. ..Jacksonville
Izlar, W. H. Waycross, Ga.
Jelks, Edward,
Riverside Hospital.....Jacksonville
†Jennings, Charles L.,
General Delivery, Winnsboro, S. C.
Johnston, C. W.,
355 St. James Bldg....Jacksonville
Keisling, Frederick C.,
315 Professional Bldg., Jacksonville
Killinger, R. R.,
St. James Bldg. Jacksonville
King, Fletcher G.,
1855 Laura St.....Jacksonville
Kirby-Smith, J. L.,
1115 Greenleaf Bldg., Jacksonville
Kirk, Wm. W.,
608 Greenleaf Bldg....Jacksonville
Klein, Lawrence A.,
P. O. Box 178 Live Oak
Knauer, W. Jerome,
Buckman Bldg.....Jacksonville
Knight, A. Comer,
Professional Bldg.....Jacksonville
Krueger, F. W.,
450 St. James Bldg....Jacksonville
Laffitte, L. Sydnor,
Medical Arts Bldg.....Jacksonville
Limbaugh, Louie M.,
357 St. James Bldg....Jacksonville
Lipscomb, T. H.,
St. Lukes Hospital Jacksonville
Lovejoy, John,
202 Medical Arts Bldg., Jacksonville
Lyerly, J. G.,
1022 Park St. Jacksonville
McCullagh, William H.,
441 St. James Bldg....Jacksonville
McEuen, H. Bernard,
402-5 St. James Bldg...Jacksonville
§McGinnis, Robert H.,
2063 Oak St.....Jacksonville
McIver, Robert B.,
1108 Greenleaf Bldg. ..Jacksonville
McKenzie, Albert C.,
St. James Bldg. Jacksonville
Manhoff, Ben,
47 W. Duval St. Jacksonville
Manning, Wm. Saunders,
310 Greenleaf Bldg. ..Jacksonville
May, Robert D.,
302 Professional Bldg..Jacksonville
Mendoza, Carl Clifford,
345 St. James Bldg...Jacksonville
Merritt, J. Webster,
2033 Riverside Ave. ..Jacksonville
Milam, Ernest B.,
Medical Arts Bldg.....Jacksonville
Mitchell, George M.,
712 Laura St. Jacksonville
Mitchell, John H.,
300 Professional Bldg..Jacksonville
Moe, Leonard N.,
212 St. James Bldg....Jacksonville
Morris, S. A.,
237 W. Duval St.....Jacksonville
Norris, S. R.,
Medical Arts Bldg. ...Jacksonville
Norwood, J. K.,
211 St. James Bldg.....Jacksonville
Oberdorfer, Aaron Z.,
409 St. James Bldg.....Jacksonville
Oetjen, G. F.,
211 E. Forsyth St.....Jacksonville
Owens, J. H.,
355 St. James Bldg. ..Jacksonville
Palmer, Thomas M.,
1819 Goodwin St. Jacksonville
Parramore, James B.,
P. O. Box 855, Chapel Hill,
North Carolina
Pasco, J. D.,
Medical Arts Bldg.....Jacksonville
Peterson, C. A.,
St. James Bldg. Jacksonville
Peyton, Harry A.,
2033 Riverside Ave.....Jacksonville
Proctor, Harper L.,
325 Peninsular Life Bldg.,
Jacksonville
Quasser, Adolph B.,
352 St. James Bldg....Jacksonville
Ramage, Raymond B.,
219-20 Professional Bldg.,
Jacksonville
Randolph, J. H.,
St. James Bldg.....Jacksonville
Richards, Ferdinand,
614-16 Greenleaf Bldg..Jacksonville
Richardson, George W.,
343 St. James Bldg....Jacksonville
Richardson, Shaler
111 W. Adams St. Jacksonville
Roberts, Earl.....Jacksonville Beach
Rogers, W. W.,
Professional Bldg.....Jacksonville
Rollins, Clarence D.,
Southside General Hospital,
South Jacksonville
Ross, William E.,
St. James Bldg.....Jacksonville
Royce, Clayton E.,
P. O. Box 2098, W. Bay Annex,
Jacksonville
Safer, Jacob V.,
452 St. James Bldg.....Jacksonville
Sanderson, Raymond,
216 Professional Bldg...Jacksonville
Sandusky, C. M.,
28 W. Monroe St.....Jacksonville
Schnauss, Fauntleroy H,
318 Hildebrandt Bldg., Jacksonville
Schnauss, William R.,
312 Hildebrandt Bldg...Jacksonville
Sellers, E. T.,
412 St. James Bldg....Jacksonville

* Deceased. † Honorary Member. § Life Member.

Sengstak, E. P. E. Mandarin
Simpson, J. Knox,
712 Laura St.....Jacksonville
Slaughter, Frank G.,
Riverside Hospital Jacksonville
Stinson, W. M.,
1611 Aberdeen St. Jacksonville
Stollenwerck, A. D.,
2005 Oak St.....Jacksonville
Strumpf, Irving J.,
344 St. James Bldg....Jacksonville
Swift, Edwin C.,
614-16 Greenleaf Bldg., Jacksonville
Taylor, H. Marshall,
111 W. Adams St.....Jacksonville
Teeter, E. H.,
305 St. James Bldg....Jacksonville
Thomas, Robert Y. H.,
502-6 Lynch Bldg. Jacksonville
Thompson, David C. Azucar
Tyler, L. V.,
San Marco Square, So. Jacksonville
Upchurch, N. A.,
City Board of Health..Jacksonville
Vallotton, J. Ralph,
214 S. Palmetto Ave.,
Daytona Beach
VanSchaick, H. D.,
210 St. James Bldg....Jacksonville
Veal, Ernest W.,
25 Miami Road ...So. Jacksonville
Waas, Frederick J.,
Professional Bldg.....Jacksonville
Washburn, Clayton D.,
St. James Bldg.....Jacksonville
Watt, E. C.,
613 Greenleaf Bldg. ...Jacksonville
Wilcox, C. R.,
712 Laura St.....Jacksonville
Wilkinson, A. H.,
313 Professional Bldg., Jacksonville
Wilson, A. K.,
334 St. James Bldg., Jacksonville
Wilson, J. F.,
310 Greenleaf Bldg. ..Jacksonville
Woolsey, B. F.,
320 St. James Bldg....Jacksonville
Wynn, Robert S.,
305 Consolidated Bldg..Jacksonville

ESCAMBIA COUNTY MEDICAL SOCIETY (DISTRICT "A")

Ames, Allen M., President,
206 Blount Bldg. Pensacola
Turberville, J. I., Vice-President,
Century
Hoffman, James M., Sec'y-Treasurer,
6 W. Chase St.....Pensacola
Anderson, W. E.,
511 Am. Natl. Bk. Bldg., Pensacola
Bell, John D.,
505 Blount Bldg.....Pensacola
Born, Charles C.,
513 Blount Bldg.....Pensacola
Bryans, Herbert L.,
21½ E. Wright St.....Pensacola
Daniels, J. P.,
321 Brent Bldg. Pensacola
Dodson, M. W.,
P. O. Box 57.....Alaflora, Ala.
Fellows, J. H.,
Brent Bldg. Pensacola
Fisher, Luther C., Jr.,
513 Amer. Natl. Bk. Bldg.,
Pensacola
Gachet, N. L. Century
Haisfield, A. R.,
311 Blount Bldg.....Pensacola
Haisfield, H. B.,
311 Blount Bldg.....Pensacola
Heinberg, Chas. J.,
506 Blount Bldg. Pensacola
Hogan, Cecil M.,
2151 Pearl St.....Jacksonville
Holley, John C. Milton
Kennedy, S. G.,
511-12 Am. Natl. Bk. Bldg.,
Pensacola
Lischkoff, M. A.,
Blount Bldg. Pensacola
McGuire, J. J.,
Pensacola Hospital.....Pensacola
McLane, J. N.,
204 W. Brainard St.....Pensacola
*McMillan, D. W.,
Scotland House Pensacola
McSween, J. C. Pensacola
Middlebrooks, Violet,
505 Amer. Natl. Bk. Bldg.,
Pensacola
Mock, A. E.,
211 Blount Bldg. Pensacola
Nobles, Robert G.,
Blount Bldg.....Pensacola
Nobles, V. R.,
Blount Bldg.....Pensacola
Nobles, W. D.....Pensacola
Payne, W. C.,
Blount Bldg. Pensacola
Pickett, W. H.,
St. Bd. of Health Bldg., Pensacola
§Pierpont, Juriah H.,
511 Amer. Natl. Bk. Bldg.,
Pensacola
Quina, M. E.....Pensacola
Stokes, Thos. H.,
Theisen Bldg. Pensacola
Sullivay, Rosa L.,
1016 W. Chase St.....Pensacola
Thames, Rufus Milton
Turberville, John S.....Century
Turner, John B.,
(Santa Rosa County) Bagdad
Webb, Carol C.,
210-11 Blount Bldg.....Pensacola
White, Alvyn W.,
P. O. Box 1345 Pensacola

HILLSBOROUGH COUNTY MEDICAL SOCIETY (DISTRICT "D")

Blake, Wm. C., President,
419 Citizens Bk. Bldg.....Tampa
Black, Robert C., Vice-President,
101 San Ever St. Plant City
Grable, James S., Sec'y-Treasurer,
811 Citizens Bk. Bldg. Tampa
Adamo, Frank S.,
Box 1626 Tampa
Adamson, William P.,
610 Citizens Bank Bldg.....Tampa
Alsobrook, J. W.,
120 N. Collins St.....Plant City
Andrews, C. A.,
715 Citizens Bank Bldg.....Tampa
Austin, Edgar Plant City
Barker, Frank T.,
302 Krause Bldg.....Tampa
Bartlett, Chas. W.,
310 First Natl. Bk. Bldg.....Tampa
Beyer, A. R.,
P. O. Box 527.....Tampa
Bidwell, A. M.,
401 First Natl. Bk. Bldg.....Tampa
Bitzer, Emory W.,
815 Citizens Bank Bldg.....Tampa
Blackmon, H. J.,
Citizens Bank Bldg.....Tampa
Boling, John R.,
1207-11 First Natl. Bk. Bldg.,
Tampa
Bottari, Giulio C.,
1202-4 1st Natl. Bk. Bldg...Tampa
Bradshaw, Virgil M.,
316 Citrus Exchange Bldg..Tampa
Brown, H. O.,
215 Madison St. Tampa
Butchart, T. R.,
804 Grand Central Ave.....Tampa
Carlton, Leland F.,
805 Citizens Bank Bldg.....Tampa
Carter, E. F.,
1903 Grand Central Ave.....Tampa
Chandler, J. C.,
410 Citrus Exchange Bldg...Tampa
Coleman, John A.,
105 N. Collins St. Plant City
Cook, George L.,
442 W. Lafayette St.....Tampa
Cook, H. M.,
107 Parker St.....Tampa
Cowart, J. T.,
1111 Citizens Bank Bldg. ...Tampa
Crum, J. W.,
413 Central Office Bldg.....Tampa
Dickinson, J. C.,
304 Citizens Bk. Bldg.....Tampa
Dominguez, J. A.,
P. O. Box 5745 Tampa
Draper, A. D.,
5607 Florida Ave. Tampa
Duke, Roncie R.,
708 Citizens Bank Bldg.....Tampa
Duncan, W. P.,
803 Tampa Theatre Bldg....Tampa
Dyer, W. H.,
1801½ 22nd St. Tampa
Efird, Lester J.,
1019 W. Platt St.....Tampa
Ely, R. A.,
404½ Zack St.....Tampa
Estes, J. L.,
815 First Natl. Bk. Bldg.....Tampa
Etheredge, S. H.,
706 Franklin St.....Tampa
Ferlita, Americo James,
2512 15th Ave. Tampa
Ferrante, G. C.,
205 Zack St. Tampa
Forbes, Sherman B.,
409 Citizens Bank Bldg.....Tampa
Garcia, Louis J.,
442 W. Lafayette St. Tampa
Garcia, Parsons M.,
P. O. Box 7224 West Tampa
Gilbert, Elsie,
6508 Central Ave.....Tampa
Gilmer, E. S.,
416 Citizens Bk. Bldg.....Tampa
Gonzalez, A. A.,
1725½ Seventh Ave.....Tampa
Grantham, James M.,
442 Lafayette Arcade.....Tampa
Grimal, A. S.,
O'Reilly 49, 6th Floor,
Havana, Cuba
Guerra, Julio J.,
First Natl. Bk. Bldg.....Tampa
Gyland, Stephen P.,
215 Madison St.....Tampa
*Hardy, G. E. W.,
818 First Natl. Bank Bldg., Tampa
Helms, John S., Jr.,
Box 1856 Tampa
Higgins, Allen F.,
442 W. Lafayette St.....Tampa
Holloway, E. W.,
205 7th Ave. Tampa
Holton, W. J.,
119 E. Reynolds St. Plant City
Hopkins, Clack D.,
1818 Hills Ave. Tampa
Jefferson, Rollin,
818 First Natl. Bk. Bldg....Tampa
Jensen, Henry J.,
7303 Nebraska Ave.....Tampa
Jobson, A. M. C.,
702 Citizens Bk. Bldg.....Tampa
Knauf, A. R.,
706 Franklin St.....Tampa
Knight, J. C.,
121 N. Collins St.....Plant City
Knowlton, Horace A.,
922 Citizens Bk. Bldg.....Tampa
Lake, Esley T.,
P. O. Box 8968.....Tampa
Lancaster, Wm. J...Wilmington, N. C.
Lowry, Blackburn W.,
1019 Citizens Bk. Bldg.....Tampa
McClosky, B. Martin,
1801½ 22nd St.....Tampa
McEachern, James R.,
P. O. Box 2214.....Tampa
*McKay, R. H.,
303 Ingraham Bldg. Miami
McLaws, R. B.,
108 E. Columbus Drive.....Tampa
Maguire, Thomas C.,
104 S. Collins St.....Plant City
Maner, George R.,
5309 Central Ave. Tampa
Marcus, Nathan L.,
706 Franklin St. Tampa
Martin, Douglas D.,
442 W. Lafayette St. Tampa
Martorell, Abelardo,
215 Madison St. Tampa
Meighen, Douglas G.,
Citrus Exchange Bldg.....Tampa
Metzger, Frank C.,
916-17 Citizens Bk. Bldg.....Tampa
Mills, Herbert R.,
706 Franklin St.....Tampa
Mills, John H.,
907 17th Ave. Tampa
Minardi, Joseph A.,
2203½ Seventh Ave.....Tampa
Mitchell, L. B.,
P. O. Box 1020.....Tampa
Moore, John T.,
317 Tribune Bldg.....Tampa
Murphey, David R., Jr.,
611 Citizens' Bank Bldg. ...Tampa
Myers, W. C.,
302 Schulte-United Bldg.....Tampa
Nelson, Robert G.,
712 Citizens Bank Bldg.....Tampa
†Oppenheimer, Louis S.,
108 Crescent Place Tampa
Ortega, Rafael,
P. O. Box 5513, Ybor Sta...Tampa
Paniello, Santiago,
P. O. Box 5105, Ybor City..Tampa
Pate, J. C.,
1107-9 1st Nat. Bk. Bldg....Tampa
Patterson, William,
312 Citrus Exchange Bldg...Tampa

* Deceased. † Honorary Member. § Life Member.

Pease, Charles W.,
State Board of Health.....Tampa
Perzia, Anthony P.,
Citizens Bk. Bldg. Tampa
Porro, Gustavo F.,
1915½ 14th St. Tampa
Portocarrero, N. A.,
1915½ 14th St.....Tampa
Rankin, Grover C.,
P. O. Box 1313.....Tampa
Rector, Lee T.,
Citizens Bank Bldg.....Tampa
Roig, Guillermo,
2710 Nebraska Ave. Tampa
Rowlett, William M.,
P. O. Box 786 Tampa
Rudisill, C. A.,
706 Franklin St.....Tampa
Sanchez, Butler H.,
15-17 Lee Bldg. Plant City
*Saxton, J. J.,
2005 Tampa St. Tampa
Scolaro, Joseph D.,
2022½ 7th Ave., Ybor City, Tampa
Shaver, E. F.,
Tampa Theatre Bldg.....Tampa
Smith, Burdette,
411 Citrus Exch. Bldg.....Tampa
Smith, H. Mason,
1019 Citizens Bk. Bldg.....Tampa
Smith, James G., Jr.,
1810 3rd Ave. ...Birmingham, Ala.
Smoak, Edward,
315 Citizens Bank Bldg.....Tampa
Snow, H. O.,
1903 Grand Central Ave.....Tampa
Spengler, Nathaniel L.,
903 Tampa Theatre Bldg.....Tampa
Spoto, Joseph S.,
Hillsborough Co. Health Unit,
Tampa
Stone, Alvord L.,
102 E. Hillsborough Ave....Tampa
Stringer, Sheldon,
P. O. Box 105 Tampa
Taylor, Joseph W.,
Room 807, 706 Franklin St., Tampa
Torbett, R. S.,
409 First Natl. Bk. Bldg.....Tampa
Torretta, Joseph N.,
1725½ E. Bdwy. Tampa
Truelsen, Thomas,
Room 605, 706 Franklin St...Tampa
Vaughan, Cecil,
228 Lafayette Arcade.....Tampa
Vinson, J. C.,
1st Natl. Bk. Bldg.....Tampa
Weekley, Augustine S.,
416 Citrus Exchange Bldg., Tampa
Whitaker, Harper E.,
2112 Watrous Ave. Tampa
Winton, M. R.,
402 Citrus Exchange Bldg...Tampa

JACKSON COUNTY MEDICAL SOCIETY (DISTRICT "A")

Whitaker, C. D., President,
Dekle Bldg. Marianna
Price, C. J.,
Vice-President Alford
Pierce, J. Lewis, Sec'y-Treasurer,
Marianna
Baltzell, N. A.....Marianna
Box, C. C. Graceville
Burns, M. Q.....Blountstown
Chappell, F. V.,
care Johns Hopkins, Baltimore, Md.
Dowling, J. B.....Alliance
Gainey, J. G. Blountstown
Joyner, R. N.,
County Health Officer ...Marianna
McKinnon, Daniel Angus....Marianna
Miller, Redden Lee,
P. O. Box 186.....Graceville
Ryals, C. H.,
R. F. D. No. 1.....Grand Ridge
Wandeck, W. R. Marianna

LAKE COUNTY MEDICAL SOCIETY (DISTRICT "E")

Williams, Rabun H., President,
Theatre Bldg. Eustis
Oetjen, Leroy H., Vice-President,
1028 W. Main St.....Leesburg
Ashton, W. Lee, Sec'y-Treasurer,
Umatilla
Bowen, Louis R.,
P. O. Box 905.....Eustis
Coleman, E. M. Clermont
Colley, Sanford C. Tavares
Conklin, Raymond C.,
141 W. 6th Ave.....Mount Dora
DeVane, W. G. Groveland
Fenn, Harry Todd.....Mount Dora
Hannum, M. M.....Eustis
Hawkins, A. S.,
779 Montrose St.....Clermont
Holland, Howard G.,
1112 W. Main St.....Leesburg
Morrison, Harry K.,
601 W. Magnolia Leesburg
Strickland, Edgar E. Mt. Dora
Tyre, C. McK.....Eustis
Wood, Will L. Mt. Dora

LEE COUNTY MEDICAL SOCIETY (DISTRICT "D")

Grace, William H., President,
Box 907 Ft. Myers
Newton, Robley D., Vice-President,
Ft. Myers Beach Hotel...Ft. Myers
Jones, H. Quillian, Sec.-Treasurer,
18-20 Leon Bldg. Ft. Myers
Bartleson, Fred Ft. Myers
Bostelman, Ernest,
201 Pythian Bldg.....Ft. Myers
Johnson, M. F. Box 1266, Ft. Myers
Longbrake, Guy,
308 Second St.....Ft. Myers
Merrick, C. Gordon,
26 Leon Bldg.....Ft. Myers
Stipe, Harvie J.,
39 Earnhardt Bldg. Ft. Myers
Whisnant, Baker,
3 Leon Bldg.....Ft. Myers

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY (DISTRICT "A")

Godard, Robert Fain, President,
Key Bldg. Quincy
*Beggs, John Miller, Vice-President,
Fla. State Hosp.....Chattahoochee
Wilkinson, B. A., Sec'y-Treasurer,
Telephone Bldg. Tallahassee
Barnes, Benjamin F....River Junction
Brevard, E. M.,
Lively Corner.....Tallahassee
Brinson, John B.,
Dogwood St.....Monticello
Brown, C. W., Jr.,
506 Exch. Bank Bldg., Tallahassee
Clements, Ralph M. Chattahoochee
Conter, A. E. Apalachicola
Daves, F. E. Chattahoochee
Davis, Julius C.,
Cor. Jefferson & Adams Sts., Quincy
Dozier, L. L.....Tallahassee
Dykes, Chapman Carrabelle
Graves, L. J.,
P. O. Box 623.....Tallahassee
Griffin, Taylor W.,
Cor. Jefferson & Adams Sts., Quincy
Gwynn, Geo. H., Jr.,
Telephone Bldg. Tallahassee
Howell, Harry S.,
Blanche Hotel Annex...Lake City
Jenkins, O. W. Chattahoochee
Johnson, A. B. Chautaqua, N. Y.
Johnston, J. Kent.,
Exchange Bk. Bldg.....Tallahassee
Kendrick, Odis G. Tallahassee
Knight, C. M. Chattahoochee
Logie, Arthur J.,
care St. Bd. of Health, Jacksonville
McClure, Herbert A.,
Director Co. Health Unit....Perry
Massey, Wm. W.,
204 N. Madison St.....Quincy
Moor, F. Clifton,
Telephone Bldg.....Tallahassee
Palmer, Henry E.,
408 S. Adams St.....Tallahassee
Pound, J. H.,
349 Fletcher St...Thomasville, Ga.
Rhodes, Bricey M.,
201 S. Monroe St. Tallahassee
Robertson, J. C. Chattahoochee
Rogers, W. D. Chattahoochee
White, Sarah Parker,
217 Sunset Lane Tallahassee
Wilhoit, Sterling E.....Quincy
Williams, J. F. Monticello
Williams, John L. Tallahassee

MADISON COUNTY MEDICAL SOCIETY (DISTRICT "B")

Long, Eustace, President.....Madison
Davis, George O.,
Sec.-Treasurer Madison
Thorpe, E. D. Madison

MANATEE COUNTY MEDICAL SOCIETY (DISTRICT "D")

Hollingsworth, S. G., President,
451 12th St. Bradenton
Larrabee, Chas. Wm., Vice-President,
Larrabee Hospital Bradenton
Harrison, M. M., Secy-Treasurer,
Bradenton
Blake, L. W. Bradenton
Field, Charles H. Bradenton
Floyd, A. J.,
Lloyd-Hughes Bldg.....Palmetto
Gates, Hubbard,
Box 245 Bradenton
Lancaster, B. M. Manatee
McDuffee, T. M. Manatee
Mason, John Franklin.....Bradenton
Sugg, William D.,
Bradenton Bk. Bldg....Bradenton

MARION COUNTY MEDICAL SOCIETY (DISTRICT "B")

Moore, J. N., President,
210-12 Prof. Bldg. Ocala
Lytle, Carl S., Vice-President,
Dunnellon
Cumming, Richard C., Sec'y-Treasurer,
Commercial Bank Bldg.....Ocala
Cammack, K. R.....Gulf Hammock
Chalker, James L.,
719 E. Ocklawaha Ave.....Ocala
Dozier, Henry C.,
9 N. Magnolia St.....Ocala
Ferguson, R. D.,
P. O. Box 802 Ocala
Freeman, Albert H.,
Holder Block.....Ocala
Futch, Thomas A., Jr.,
Commercial Bank Bldg.....Ocala
Gatrell, Henry Fairfield
Hanson, Edwin C. Belleview
†Hood, J. W. Ocala
Lindner, E. G.....Ocala
Lisk, Percy F.....Ft. McCoy
Martin, Irl E. Ocklawaha
Mimms, Carney W.,
Commercial Bank Bldg. Ocala
Peek, Eugene G.,
Commercial Bank & Trust Bldg.,
Ocala
Russell, Ralph E.....Ocala
Scott, E. L., 114 S. Main St.....Ocala
Slaughter, T. K. Wildwood
Strange, J. L.....McIntosh
Wallis, Thomas H.,
104 S. Magnolia St. Ocala
Watt, H. F., Box 146 Ocala

MONROE COUNTY MEDICAL SOCIETY (DISTRICT "F")

Galey, Harry C., President,
532 Fleming St. Key West
Pintado, Nilo C., Vice-President,
412-13 Postal Bldg.....Miami
Warren, William R., Sec'y-Treasurer,
511 Eaton St.....Key West
DePoo, Julio J.,
330 Duval St. Key West

ORANGE COUNTY MEDICAL SOCIETY (DISTRICT "E")

Sinclair, W. E., President,
Clinic Bldg. Orlando
Harms, F. H., Vice-President,
64 N. Court St. Orlando
Pines, John A., Secretary,
106-10 E. Central Ave.....Orlando
Folsom, Spencer A., Treasurer,
319-22 Exchange Bldg.....Orlando
Anderson, Claude,
1400 E. Church St. Orlando
Andrews, M. M., Box 1817.....Orlando
Beach, M. L.,
Fla. Bk. Bldg. Orlando
Beardall, Harold M.,
147 E. Church St.....Orlando
Brame, Dorothy D.,
316-18 Exchange Bldg.....Orlando
Buff, Julian H.,
49 N. Orange Ave.....Orlando
Burks, B. Auxford,
108 E. Park Avenue...Winter Park
Butler, Paul T.,
23 Autrey Arcade.....Orlando
Carson, Russell B.,
311 Exchange Bldg Orlando
Chappell, John R.,
P. O. Box 1370 Orlando

* Deceased. † Honorary Member. § Life Member.

Chiles, J. H. Holopaw
Christ, Calvin D.,
P. O. Box 1137.....Orlando
Christie, Gerard E.,
P. O. Box 151.....Titusville
Collins, Chas. J.,
209-12 Exchange Bldg. Orlando
Day, Horace A.,
209-12 Exchange Bldg.....Orlando
Dodds, William Henry,
11th St. & Pa. Ave.....St. Cloud
Gardner, J. F. Winter Park
Gray, Frank D.,
11 Lucerne Circle Orlando
Gwathmey, G. Tayloe,
710 Fla. Bank Bldg.....Orlando
Gwynn, H. W.,
Clinic Bldg.....Orlando
Hart, Ruth S. Winter Park
Henderson, R. P.,
215 Exchange Bldg. Orlando
Hoffmann, C. D.,
120 E. Robinson Ave.....Orlando
Hotard, Roland F.,
226 E. Park Ave.....Winter Park
Ingram, L. C.,
P. O. Box 1711.....Orlando
Jewitt, Eugene L.,
11 Lucerne Circle Orlando
†Johnston, Colonel Geo. C.,
P. O. Box 272.....Orlando
Johnston, Hewitt,
P. O. Box 2002 Orlando
Knowles, Harold S.,
215 Exchange Bldg. Orlando
Lawrence, E. J. Winter Garden
Lawson, Ben Hill.....Winter Garden
†Lewis, P. M.,
P. O. Box 346 Orlando
Lynn, C. W.,
Fla. Sanitarium.....Orlando
McBride, Thomas E.....Apopka
McEwan, Duncan T.,
106-10 E. Central Ave.....Orlando
McEwan, John S.,
106-10 E. Central Ave.....Orlando
McGugan, Arthur,
646 Seminole Drive...Winter Park
Mallory, Meredith,
P. O. Box 1011.....Orlando
Morton, B. Rosalie Slaughter,
Winter Park
Neal, Thomas Albert,
P. O. Box 321 Orlando
Oertel, H. B. Osceola
Orr, Louis McDonald,
311 Exchange Bldg.....Orlando
Osincup, Gilbert S.,
300 E. Colonial Drive.....Orlando
Page, W. Grady,
State Bank Bldg.....Orlando
Quillman, Frank L.,
11 S. Main St. Winter Garden
Redding, John L.,
209 S. Orange Ave.....Orlando
Ricker, Samuel F.,
33 E. Livingston Ave.....Orlando
Rivers, T. M. Kissimmee
Rue, Doran T.,
311 Exchange Bldg. Orlando
Shoemaker, Samuel A.,
30 E. Church St.....Orlando
Spiers, Wm. Henry,
P. O. Box 1712 Orlando
Sutter, Leroy M.,
140 N. Orange Ave. Orlando
Taylor, B. E.,
Florida Sanitarium.....Orlando
Weed, Walter Alva,
2nd Floor, Exchange Bldg., Orlando
White, Roland T.,
211 S. Rosalind Ave.....Orlando
Williamson, Carolyn G.,
310 E. South St. Orlando
Wood, Robert G.....St. Cloud

PALM BEACH COUNTY MEDICAL SOCIETY (DISTRICT "F")

Rozier, L. McK., President,
411-14 Comeau Bldg.,
W. Palm Beach
Heath, Guy W., Vice-President,
409-11 Harvey Bldg.,
W. Palm Beach
Netto, Lloyd J., Secretary,
415 Comeau Bldg., W. Palm Beach
Herpel, Frederick K., Treasurer,
P. O. Box 1057.....W. Palm Beach
Arnold, Wilbur Ogden,
P. O. Box 1735.....W. Palm Beach
Baldwin, R. Henry,
1101 Harvey Bldg...W. Palm Beach
Binkley, John Frey,
1206 Harvey Bldg...W. Palm Beach
Blair, William M.,
424 Comeau Bldg...W. Palm Beach
Boynton, Charles E., Jr.,
1023 Comeau Bldg., W. Palm Beach
Brantley, Grady H.,
P. O. Box 336.....Lake Worth
Clarholm, Victor,
Harvey Bldg. W. Palm Beach
Cooley, Roy Oscar,
P. O. Box 1735.....W. Palm Beach
Cram, George E.,
223 Sunset Ave. Palm Beach
Creel, Charles E.....Pahokee
Davis, K. M.,
Central Arcade Delray Beach
Dawson, George M.,
P. O. Box 1836.....W. Palm Beach
Denison, Raymond C.,
521 Lake Ave.....Lake Worth
Ebert, J. William,
Harvey Bldg. W. Palm Beach
Elarbee, George W. Pahokee
Fleming, Samuel Ward,
417 Harvey Bldg...W. Palm Beach
Gardner, William H.,
Comeau Bldg.....W. Palm Beach
George, Wm. W.,
1116 Harvey Bldg., W. Palm Beach
Gill, Richard S.,
Box 2004 W. Palm Beach
Hazen, Olen B.,
Comeau Bldg. W. Palm Beach
Henry, Gordon F.,
305 Citizens Bldg....W. Palm Beach
Jackson, Noah,
312 Hibiscus St.....W. Palm Beach
Johnson, Vesey M.,
Good Samaritan Hospital,
W. Palm Beach
King, Graham W., Jr.,
Love Bldg. Delray Beach
Lewis, Gaylord,
916 Harvey Bldg...W. Palm Beach
Miller, Alice R.,
418 Fern St.....W. Palm Beach
Newnham, J. A.,
511 Harvey Bldg....W. Palm Beach
Nowling, James C.,
309 Harvey Bldg....W. Palm Beach
Papot, Grace E.,
811 Harvey Bldg....W. Palm Beach
Pittman, J. H.,
P. O. Box 552.....W. Palm Beach
Powell, J. A.,
627 So. Olive.....W. Palm Beach
Randall, Floyd H.,
Boca Raton Club.....Boca Raton
Rowe, Alva L.....Lake Worth
Sayad, William Y.,
1215 Harvey Bldg..W. Palm Beach
Schiffli, O. F. Clewiston
Shackelford, C. W.....W. Palm Beach
Shackelford, W. L. W. Palm Beach
Sory, B. B., Jr.,
Brazilian Court Hotel, Palm Beach
Sory, James R.....Lake Worth
Stone, Vale D.,
Harvey Bldg. W. Palm Beach
Van Landingham, William E.,
P. O. Box 758.....W. Palm Beach
Wakefield, Harry A.,
810 Comeau Bldg...W. Palm Beach
Waller, Constantine B.,
Harvey Bldg. W. Palm Beach
Warren, Hobart E.,
Phipps Plaza.....Palm Beach
Weems, Nat. M.....Boynton
Whitman, Frank S.,
512 Comeau Bldg....W. Palm Beach
Wilber, A. B.,
170 Seaview Ave.....Palm Beach
Williams, Wm. Chas., Jr.,
402 Comeau Bldg...W. Palm Beach
Young, Wilburn C. Canal Point

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY (DISTRICT "B")

Sistrunk, Robert D., President,
Dade City
Harvard, S. C., 1st Vice-President,
Brooksville
Hudson, P. J.,
2nd Vice-President ..Crystal River
Bourke, John J.,
Secy.-Treas. Dade City
Bradshaw, J. T. San Antonio
Cannon, Augustus B.....Lacoochee
Coogler, A. C. Brooksville
Creekmore, George R.,
112 N. Main St.....Brooksville
Dame, George A.,
241 Main St.....Inverness
Dame, Leland H.,
Dist. Health Officer, W. Palm Beach
Jones, W. Wardlaw.....Dade City
Mills, David A.....Zephyrhills
Moon, William B.....Crystal River

PINELLAS COUNTY MEDICAL SOCIETY (DISTRICT "D")

Kauffman, Frank E., President,
Coachman Bldg Clearwater
Nettles, Robbins, 1st Vice-President,
402-5 Coachman Bldg. ..Clearwater
Heibner, E. A., 2nd Vice-President,
Power & Light Bldg.,
St. Petersburg
McConnell, W. C., Sec'y-Treas.,
1005 Equitable Bldg., St. Petersburg
†Albaugh, Andrew P....Tarpon Springs
Anderson, Arnold S.,
712 Power & Light Bldg.,
St. Petersburg
Anderson, C. O.,
333 Third St. N.....St. Petersburg
Anderson, J. M.,
333 Third St. N.....St. Petersburg
Anderson, Wm. D.....Tarpon Springs
Bieker, Annette M.,
825 Power & Light Bldg.,
St. Petersburg
Bieker, Arthur J., Jr.,
360 4th St. S. St. Petersburg
Black, M. Eldridge,
311 Coachman Bldg.....Clearwater
Bowen, John T.,
Coachman Bldg. Clearwater
Bradford, W. H.,
U. S. Veterans Hospital..Bay Pines
Center, R. H.,
Coachman Bldg.....Clearwater
Cooper, J. H.,
First Natl. Bk. Bldg., St. Petersburg
Davis, W. M.,
342 First Ave. N.....St. Petersburg
Dawson, S. A.,
870 Seventh Ave. N., St. Petersburg
Dickerson, L. B.,
Williamson Bldg.....Clearwater
Dicks, Reid E.,
632 22nd St. S.....St. Petersburg
Echard, T. B.,
203 Equitable Bldg., St. Petersburg
Farber, C. K.,
1110 Highland St. S., St. Petersburg
Farber, William P.,
807 Power & Light Bldg.,
St. Petersburg
Feaster, O. O.,
St. Anthony's Hosp., St. Petersburg
Frederick, A. R.,
614 Power & Light Bldg.,
St. Petersburg
Funk, Neil E.,
702 Power & Light Bldg.,
St. Petersburg
Gable, Linwood M.,
Power & Light Bldg., St. Petersburg
Gable, Nonie Wilson,
Health Department,
175 Fifth St. N.....St. Petersburg
Gable, Nonie Worth,
706 Power & Light Bldg.,
St. Petersburg
Gowe, Donald F.,
1252 Corona St.....Denver, Col.
Green, T. H.,
614 Hall Bldg.....St. Petersburg
Griffin, Thos. R.,
Power & Light Bldg., St. Petersburg
Groves, W. H.....Clearwater
Guinand, P. H.,
Jackson Bldg. Clearwater
Harden, W. W.,
814 1st Natl. Bk. Bldg.,
St. Petersburg
Hardenbergh, John A.,
404 Power & Light Bldg.,
St. Petersburg
Hebard, C. E.,
Fla. Natl. Bk. Bldg., St. Petersburg
Herring, John A.,
259 3rd St., N. St. Petersburg
Horne, Lester W.,
Power & Light Bldg., St. Petersburg
Jennings, Frank S.,
248 Third St. N.....St. Petersburg
Knowlton, R. H.,
Power & Light Bldg., St. Petersburg
Lambdin, L.,
332 4th St., N.....St. Petersburg

• Deceased. † Honorary Member. § Life Member.

Langley, Francis H.,
614 Times Bldg.....St. Petersburg
LeBreton, Prescott,
American Legion Hospital,
St. Petersburg
Leith, R. B.,
201 Snell Bldg.....St. Petersburg
Lochner, G. M.,
406 Power & Light Bldg.,
St. Petersburg
Lustig, Emil,
500 Seventh Ave. N., St. Petersburg
MacCordy, Earl C.,
307 Equitable Bldg., St. Petersburg
Marr, Norval M.,
812 Power & Light Bldg.,
St. Petersburg
Mease, J. A., Jr.,
Virginia Avenue.....Dunedin
Melville, E. J.,
335 Third Ave. N.....St. Petersburg
Miller, George E.,
411 Third Ave. N.....St. Petersburg
Mills, Alvin L.,
308 Fla. Natl. Bk. Bldg.,
St. Petersburg
Moeller, M. W.,
1077 15th Ave., N., St. Petersburg
Murphy, Ralph D.,
P. O. Box 82.....St. Petersburg
Nelson, Orville N.,
U. S. Veterans Hosp.....Bay Pines
Nickle, M. A.,
503-5 Coachman Bldg...Clearwater
O'Brien, R. K.,
E. 105 5th Ave., N., St. Petersburg
†Osgood, G. E.,
4823 15th St. N.W.,
Washington, D. C.
Owen, W. S.,
518 Power & Light Bldg.,
St. Petersburg
†Peabody, J. D.,
456 Third St. N.....St. Petersburg
Post, Wm. G., Jr.,
814 Power & Light Bldg.,
St. Petersburg
Prather, B. T.,
701 Fla. Natl. Bk. Bldg.,
St. Petersburg
Quicksall, J. Braden,
211 Taylor Arcade, St. Petersburg
Quicksall, W. E.,
222 Taylor Arcade...St. Petersburg
Rogers, H. M.,
Equitable Bldg. St. Petersburg
Roope, A. P.,
1727 8th St. N. St. Petersburg
Roush, Franklin W.,
4689 Lakeview Ave., St. Petersburg
Rudolph, C. C.,
512 Power & Light Bldg.,
St. Petersburg
Simcox, Lawrence,
201 Third St. N.....St. Petersburg
Smithset, S. P.....Sutton's Bay, Mich.
Solomon, H. D.,
Power & Light Bldg. St. Petersburg
Stevens, Ralph E.,
Fla. State Hospital..Chattahoochee
Strickland, J. A.,
712 Power & Light Bldg.,
St. Petersburg
Stuart, M. H.,
208 Equitable Bldg., St. Petersburg
Timberlake, Gideon,
6th Floor Times Bldg.,
St. Petersburg
Wade, H. W.,
512 Power & Light Bldg.,
St. Petersburg
White, Benj. L.,
202 First Natl. Bk. Bldg.,
St. Petersburg
Whitford, Grace R.....Ozona
Williams, C. A.,
P. O. Box 975.....St. Petersburg
Winchester, H. E.,
P. O. Box 448.....Dunedin
Wood, Alvin J.,
208 Equitable Bldg., St. Petersburg
Wright, Claude B.,
214 Equitable Bldg..St. Petersburg
Wylie, Leroy A.,
210-13 Medical Arts Bldg.,
St. Petersburg

POLK COUNTY MEDICAL SOCIETY (DISTRICT "D")

Clark, Samuel A., President,
802 Marble Arcade Bldg.,
Lakeland
Shafer, W. W., Vice-President,
Haines City
Boulware, James R., Jr., Sec.-Treasurer,
P. O. Box 367.....Lakeland
Alexander, Omer R.,
Marble Arcade Lakeland
Besenbruch, Peter W.,
Orange St. Davenport
Bird, D. Paul,
Box 414 Lakeland
Bond, Benjamin J.,
301-2 Taylor Bldg., Winter Haven
Bosworth, Joe Marvin, Jr.,
Box 1202 Lakeland
Carefoot, G. M. Ft. Meade
Cline, R. L.,
P. O. Box 462.....Lakeland
Cordes, H. B., Box 84.....Frostproof
Early, C. S,
Spencer-Futch Bldg.....Lakeland
Freeman, G. C., Box 1202....Lakeland
Fuller, Henry Mulberry
Gilbert, R. E.,
19 Postal Arcade.....Winter Haven
Gilchrist, J. G.,
P. O. Box 744.....Bartow
Griffin, J. D.,
203 Hartzell Lakeland
Hargrove, Julian Leo,
Polk County Hospital.....Bartow
Harness, A. J.,
417 McDonald St. Lakeland
Harris, Esau A. Brewster
Horton, Waldo,
539 Ave. B., N. W....Winter Haven
Hughes, Robt. Lee,
225 E. Main St. Bartow
Hurlburt, C. J.....Bartow
Irons, F. E. Winter Haven
Koon, Alpheus C.,
117 So. Tenn. Ave.....Lakeland
Lancaster, L. L.,
Taylor Bldg. Winter Haven
Lester, John G.,
P. O. Box 548.....Lakeland
Lindsey, Sherrod A.....Ft. Meade
Lowry, James B.,
P. O. Box 66.....Nichols
McMurray, James W.,
Dist. Med. Officer.....Marianna
Martin, Emmett E.,
Wray Bldg. Haines City
Mooty, Ross H. Winter Haven
Murphy, C. H.....Bartow
Murphy, H. K.,
Polk & Main Sts.....Mulberry
Newman, Heber P. Bartow
Nicholson, L. B.,
307 Marble Arcade Lakeland
Overstreet, G. C.,
Marble Arcade.....Lakeland
Peacock, William F.,
Barnett-Embry Bldg.....Bartow
Pearce, C. C. Mulberry
Pennington, B. Y.....Lake Wales
Ragsdale, V. H.,
A. A. C. Co. Hospital.....Pierce
Roberts, Tenney H.,
328 N. Florida Ave.....Lakeland
Sherman, Wm. E.,
716 W. Central Ave..Winter Haven
Simmons, T. G.,
Corlett Bldg. Auburndale
Simpson, W. T.,
Taylor Bldg. Winter Haven
Smith, Samuel F.,
P. O. Box 628.....Lakeland
Stetson, A. G. C.,
Sullivan Bldg.....Lakeland
Sullivan, Raleigh R.,
1006 Marble Arcade.....Lakeland
Tillis, W. L.,
502 Marble Arcade Bldg., Lakeland
Tinkler, B. R. Lake Wales
Tomlinson, J. P., Jr.,
Alcoma Bldg. Lake Wales
Tomlinson, J. P., Sr.,
Alcoma Bldg. Lake Wales
Vaughn, John W.,
P. O. Box 475.....Lakeland
Watson, Herman,
P. O. Box 944.....Lakeland
Watson, S. Edgar, Box 944, Lakeland
Wilhoyte, R. E. Lake Wales
Williams, E. L.....Ft. Meade
Wilson, Cecil H. Bartow
Wilson, John F., Jr.,
P. O. Box 254.....Lakeland

PUTNAM COUNTY MEDICAL SOCIETY (DISTRICT "C")

Gurganious, Allen P., President,
Palatka
Drexel, A. E., Secy-Treasurer,
424 Ocean Blvd.....Daytona Beach
Bell, Emory Palatka
Ford, E. W. Crescent City
Johnson, H. A. Palatka
*Rosborough, D. Y. Palatka
Strong, S. B.,
Station Hospital, Ft. Oglethorpe, Ga.
Williams, W. J. Seville
Zeagler, G. M.,
Glendale Hospital Palatka

ST. JOHNS COUNTY MEDICAL SOCIETY (DISTRICT "C")

White, Herbert E., President,
401-5 1st Nat. Bk. Bldg.,
St. Augustine
Potter, George W., Vice-President,
East Coast Hospital..St. Augustine
Harris, R. D., Secretary..St. Augustine
Walkup, A. Clark, Treasurer,
116 St. George St.....St. Augustine
Britt, Reddin, Box 1226..St. Augustine
Grace, Chas. C.,
East Coast Hospital ..St. Augustine
Lewis, Albert W., Jr.,
405 1st Nat. Bk. Bldg.,
St. Augustine
Lockwood, Vernon A.,
East Coast Hospital..St. Augustine
Spencer, J. J. St. Augustine
Webb, Walter D. St. Augustine

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY (DISTRICT "E")

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Boothe, R. C. Ft. Pierce
Burns, Van William,
P. O. Box 922.....Stuart
Clark, H. D.,
Ft. Pierce B. & Tr. Bldg..Ft. Pierce
Foy, William E.,
710 Orange Ave. Ft. Pierce
Hardee, E. B. Vero Beach
Harrell, G. L. Vero Beach
Martin, Leon H.....Ft. Pierce
Parker, J. D., Box 942.....Stuart
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Harris, J. E., Sec.-Treas.,
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Burgner, Blanche A. Sarasota
Cribbins, O. H.,
224 Commercial Court.....Sarasota
Freund, Ernest,
Fla. Medical Center Venice
Halton, Jack, Box 1337.....Sarasota
Halton, Joseph,
Pineapple Ave. Sarasota
Hoskins, W. H.....Venice
Johnston, W. J.,
215 Commercial Court.....Sarasota
Kennedy, David R.,
1st Bk. & Tr. Bldg.....Sarasota
Mathews, A. Lamar,
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Myers, Nicholas P. Ft. Meade
Patterson, J. C.,
Palmer Nat'l Bk. Bldg.....Sarasota
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Century Club, 7 W. 43 St.,
New York
Shelby, Edmund P. Venice
Stem, Leon T.,
698 W. 7th St. Sarasota
Taylor, T. W.,
Walpole Bldg., Main St...Sarasota
Wilson, Cullen B.,
1st Bk. & Tr. Bldg. Sarasota

* Deceased. † Honorary Member. § Life Member.

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Knox, A. W.,
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Langley, W. T.,
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Martin, John W.,
P. O. Box 95.....Oviedo
Mitchell, C. M. Sanford
Moore, Thomas G. Scanlon
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Brumley Puleston Bldg. ...Sanford
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Baker, W. J. Foley
Greene, Ralph J. Perry
O'Quinn, Charles A.,
Director, Taylor County Health
Unit Perry

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Bearce, Herbert W. Port Orange
Bouchelle, Louis B. New Smyrna
Brown, L. V. L. DeLand
Chandler, J. R.,
110 S. Ridgewood Ave.,
Daytona Beach
Clemmer, Charles A.,
P. O. Box 3236.....Daytona Beach
Davis, C. W.,
231 Coates St. Daytona Beach
Davis, George A.,
Dreka Bldg. DeLand
Davis, J. B.,
Halifax Dist. Hosp., Daytona Beach
Dillard, T. H. DeLand
Doern, William G.,
1743 N. Cambridge,
Milwaukee, Wis.
*Fogarty, Joseph N.,
424 Ocean Blvd.....Daytona Beach
Forster, Davis,
701 N. Orange Ave....New Smyrna
Glatzau, L. W.,
122 S. Palmetto Ave., Daytona Beach
Green, George M.,
102½ S. Beach St....Daytona Beach
Hahn, Theodore F.,
Dreka Bldg. DeLand
Howe, Raymond,
P. O. Box 1582.....Daytona Beach
Howe, Roy,
222 Volusia Ave.....Daytona Beach
*Johnson, Harry Dash,
Box 1242 Daytona Beach
Jones, Carroll B. New Smyrna
Kindred, J. J.,
Hotel Putnam DeLand
Merryday, Harry L.....Daytona Beach
Miller, B. E.,
412 Canal St. New Smyrna
Miller, Harold E.,
102 Faulkner St.....New Smyrna
Miller, R. L.,
258½ S. Beach St...Daytona Beach
Myres, M. J.,
Room 3, 258½,
S. Beach St.....Daytona Beach
Pay, W. C.,
221 W. Rich Ave.....DeLand
Puleston, Fred,
Box L, Pen. Sta.....Daytona Beach
Rawlings, J. E.,
221 Orange Ave....Daytona Beach
Rogers, M. Josie,
436 Rogers Court....Daytona Beach
Rutter, Joseph H.,
122 S. Palmetto Ave., Daytona Beach
Stern, Maximilian,
223 Ocean Blvd.....Daytona Beach
Taylor, J. E. DeLand
Tribble, C. E.,
Dreka Bldg. DeLand
von Mysenbug, Ludo,
Box 3356 Daytona Beach
West, Hugh DeLand
Wood, Evans B.,
P. O. Box 5295.....Daytona Beach

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Defuniak Springs
McDonald, C. W., Vice-President,
Gadsden Co., Health Unit..Quincy
Williams, A. G., Secy-Treasurer,
Lakewood
Enzor, R. E. Crestview
Huggins, E. L. Freeport
Stephens, S. E. Laurel Hill

* Deceased. † Honorary Member. § Life Member.

A LETTER TO SOCIETY SECRETARIES

The following letter was mailed to the secretary of each county medical society in Florida on January 29, 1937. Your attention is called to the suggested changes to the Constitution which were proposed at the last annual meeting and which will come up for final action at the meeting of the House of Delegates which will be held in St. Petersburg in April:

"To County Society Secretary:

"Thirty days in advance of the annual meeting, the 1937 dues of your County Society members must be received by the secretary of the State Association. Please do not put this matter off as our Constitution and By-Laws stipulate that if a society fails to comply with the following provision, none of its members or delegates shall be permitted to participate in the business or proceedings of the Association or of the House of Delegates.

"The secretary of each county society shall forward its assessment, together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of this Association thirty days in advance of each Annual Meeting. (By-Laws of Assn. Chapt. VIII).

"Your Society's representation in the House of Delegates will be: one delegate for each twenty paid members or major fraction thereof. 'Paid members' in this instance means members whose annual dues have been paid for the year 1937.

"Article XI of the Constitution permits the House of Delegates to amend any article of the Constitution by two-thirds vote of delegates registered at that annual session. The following amendments were proposed at the last annual meeting and will come up for final action at the next Annual Meeting, in April:

"Article XI shall be amended to read as follows: 'Any article of the Constitution may be amended by two-thirds vote of the Delegates registered at that Annual Meeting and referred to the component county societies for ratification during the ensuing year; each society ratifying by majority vote of its members present at any regular meeting; it being necessary for three-fourths of the component societies to vote in favor of its ratification during the year.'

"Section 3, Article VII of the Constitution relative to election of officers, shall be amended to read as follows: 'The officers of this Association shall be elected by the House of Delegates

at its last regular session of the Annual Meeting, and referred to the last General Session for confirmation; and any member shall be eligible to any office named in Section 1 of Article VII of the Constitution, but no person shall be elected to such an office who is not in attendance during that Annual Meeting (except the Secretary, Treasurer, and the Editor of the Journal) and who has not been a member of the Association for five years.'

"According to the requirements of the Constitution, these actions must be officially transmitted to each component society at least two months before the meeting at which final action is to be taken. This is official notice to your component Society.

"Sincerely yours,
(Signed) SHALER RICHARDSON, M.D.,
Secy.-Treas.-Editor."

SOUTHEASTERN SURGICAL CONGRESS

The Eighth Annual Assembly of the Southeastern Surgical Congress which was scheduled to meet in Louisville, Kentucky, March 8, 9 and 10, has been transferred to Charlotte, North Carolina. It will be held on the same dates as originally scheduled.

Thirty-seven of the country's most outstanding surgeons, representing each branch of surgery, have already been placed on the program. There will be three full days of postgraduate lectures and one public meeting at which time the C. Jeff Miller Lectureship will be given. This lectureship will be the high point of the Assembly. Its purpose is to honor the late Doctor C. Jeff Miller of New Orleans. It was founded to commemorate the memory of Doctor Miller as a great surgeon and public benefactor. This Memorial Lectureship will bring together in one evening such men as Dr. W. D. Haggard, who is one of the world's greatest surgical orators and who will present the Memorial Address; Dr. Frederic A. Besley, President of the American College of Surgeons; Dr. Charles Gordon Heyd, President of the American Medical Association; Dr. J. H. J. Upham, President-elect of the American Medical Association; Dr. Frank Boland, President of the Southern Medical Association; and Dr. Fred Rankin, President-elect of the Southeastern Surgical Congress and President of the Southern Surgical Association. These surgeons will all give talks on this occasion.

On Tuesday evening the regular annual banquet will be given in the Ballroom of the Brown Hotel. Each day at the noon hour a round table conference will be held and at this time questions on lectures delivered previously may be asked the speakers. Everyone is invited to ask questions and to enter into the discussions.

Below is a list of the speakers who will take part in the program:

Abell, Irvin Louisville, Ky.
Babcock, W. Wayne Philadelphia
Besley, Frederic A. Waukegan, Ill.
Blackburn, John H. Bowling Green, Ky.
Boland, Frank K. Atlanta, Ga.
Bunch, George H. Columbia, S. C.
Churchill, Edward D. Boston, Mass.
Conwell, H. Earle Birmingham, Ala.
Craig, Winchell McK. Rochester, Minn.
Crile, George W. Cleveland, Ohio
Dicks, J. W. D. Natchez, Miss.
Gage, Mims New Orleans, La.
Gaul, J. S. Charlotte, N. C.
Haggard, W. D. Nashville, Tenn.
Herrmann, Louis G. Cincinnati, Ohio
Hertzler, Arthur Kansas City, Mo.
Heyd, Charles Gordon New York City
Horsley, J. Shelton Richmond, Va.
Jelks, Edward Jacksonville, Fla.
Kretschmer, Herman Chicago, Ill.
Lehman, Edwin P. University, Va.
Lewis, Dean Baltimore, Md.
Lowsley, O. S. New York City
Lucas, Charles DeF. Charlotte, N. C.
McLeod, James Florence, S. C.
Meeker, W. R. Mobile, Ala.
Mitchell, Edward D. Memphis, Tenn.
Novak, Emil Baltimore, Md.
Pruitt, Marion Atlanta, Ga.
Rawls, Julian Norfolk, Va.
Rush, L. H. Meridian, Miss.
Sage, Dan Y. Atlanta, Ga.
Semken, George H. New York City
Speed, J. S. Memphis, Tenn.
Spurling, Glen Louisville, Ky.
Upham, J. H. J. Columbus, Ohio
Weiland, Arthur H. Coral Gables, Fla.

For information write or wire Dr. B. T. Beasley, Secretary-Treasurer, 701 Hurt Building, Atlanta, Georgia.

STATE NEWS ITEMS

Dr. L. C. Ingram of Orlando has moved his offices to the Exchange Building in order to have sufficient room for himself and his son, Dr. H. C. Ingram, who plans to join him in June.

* * *

Dr. Ralph M. Clements has resigned his position as Assistant Physician in charge of eye, ear, nose and throat at the Florida State Hospital at Chattahoochee. Dr. Clements will enter private practice at Tuscaloosa, Ala.

* * *

Dr. John O. Barfield and Miss Edith Herlong of Miami were married December 1.

Dr. Graham E. Henson has announced his intention of limiting his practice to the diagnosis and treatment of allergic diseases. Doctor Henson's address is: St. James Building, Jacksonville.

* * *

A meeting of the Southeastern Branch of the American Urological Association was held in Charlotte, N. C., December 4 and 5. This Branch has a membership of 210, which is spread over the Southeast, 24 being from Florida. An excellent scientific program was followed by a dinner, held at the Country Club, which proved to be a most interesting affair. The attendance at the dinner was over four hundred. Dr. James L. Estes of Tampa was elected a member of the Executive Committee, representing Florida.

* * *

Dr. Frank L. Quillman, formerly of Winter Garden, announces the removal of his office to 16 North Court Street, Orlando.

* * *

Dr. and Mrs. W. Wardlaw Jones of Dade City announce the birth of a daughter, Nancy Grant, on January 15.

* * *

The New Orleans Graduate Medical Assembly will be held March 8-11 at New Orleans. Eighteen speakers of national prominence, presenting the most recent advances of medicine and surgery, have places on the program. Additional information regarding the Assembly may be secured from Dr. Thomas Benton Sellers, president, 1430 Tulane Avenue, New Orleans.

* * *

Dr. Fred Mathers, resident physician, University of Florida, Gainesville, attended the annual meeting of the American Student Health Association, held in Washington, D. C., during the Christmas holidays.

* * *

All officers of the Duval County Hospital, Jacksonville, were re-elected recently, at the annual joint meeting of the hospital staff and the Duval County Welfare Board. The officers re-elected were: Dr. Robert B. McIver, president; Dr. Clayton E. Royce, vice-president; and Dr. T. M. Palmer, secretary.

* * *

Dr. Lawrence A. Klein, formerly of Osceola, has moved to Live Oak where he has opened offices.

Dr. C. O. Anderson, 333 Third St. N., St. Petersburg, is chairman of the local committee on Alumni and Fraternity Luncheons. All groups desiring this committee to make arrangements for luncheons during the annual convention at St. Petersburg, April 5, 6, and 7, are requested to notify Doctor Anderson without delay. The more time this committee has to arrange for the special group luncheons, the better the schedule can be made.

* * *

The semi-annual meeting of the Florida Midland Medical Association was held Tuesday, October 27, at Plant City, the City Hall Auditorium being headquarters. The following scientific program was presented:

"Hirschsprung's Disease"—L. W. Martin, Sebring.

"Endocrinology in the Psychoneuroses"—W. C. McConnell, St. Petersburg.

"Recent Changes in the Treatment of Fractures in the Use of Piano Wire and Steel Pins"—Prescott LeBreton, St. Petersburg.

"Some Observations of Early Pregnancy With Special Reference to Abdominal Pains"—W. Wardlaw Jones, Dade City.

"Diagnosis and Treatment of Pathological Conditions of the Tracheobronchial Tree"—Julian H. Buff, Orlando.

"Labor in Abnormal Presentations"—Robert G. Nelson, Tampa.

"The Social Security Act As It Relates to Physicians"—J. C. Vinson, Tampa.

"Hypothyroidism"—N. M. Marr, St. Petersburg.

"Dangers and Safeguards in Giving Immune Sera"—Frank C. Metzger, Tampa.

"X-ray in the Treatment of Infections"—O. O. Feaster, St. Petersburg.

The election of officers resulted as follows:

President—C. W. Larrabee, Bradenton.

First Vice-Pres.—Leland F. Carlton, Tampa.

Second Vice-Pres.—W. C. McConnell, St. Petersburg.

Sec'y-Treas.—B. H. Sanchez, Plant City.

The next meeting is scheduled for Bradenton, April 29, at 2:00 p. m., to be followed by a dinner at 8:00 o'clock.

* * *

The Florida Society of Dermatology and Syphilology held its quarterly meeting February 20 and 21 in Miami. Dr. Wiley M. Sams was chairman for the meeting.

Dr. Thomas F. McDaniel, formerly of Sebring, has opened offices at 104½ Magnolia Ave., in the Seminole County Bank Building, Sanford. Doctor McDaniel is now in his own office, doing general practice.

* * *

Dr. C. C. Collins of Jacksonville was recently elected chairman of the Duval County Board of Public Instruction. This is the second time in his six years as a member of the board that Doctor Collins has been the presiding officer.

* * *

The American Public Health Association announces the 66th annual meeting and 19th annual health exhibit to be held at the Hotel Pennsylvania, New York, October 5 to 8, 1937, and the appointment of Dr. John L. Rice, Commissioner of Health, New York City, as chairman of the general committee.

* * *

The Committee on Medical Post-Graduate Course is hard at work on plans for the Short Course which will be held in Orlando in June. It is believed that the change from Gainesville to Orlando will make the Course accessible to more physicians of the State. Make your plans early to take advantage of this very excellent post-graduate course.

GENOUS SANDERS HODGES

Dr. Genous S. Hodges, who practiced his profession in Marianna for twenty-three years, died on December 9 of pneumonia, after an illness of six days.

Dr. Hodges was born June 15, 1881, at Headland, Alabama. He attended Emory University from which he graduated in 1912. During the World War, he served overseas from the 29th Base Hospital as first-aid physician to the 2nd and 42nd Divisions.

Dr. Hodges will be sorely missed in civic and professional circles in his community, in which he took an active interest. He was a member of the Elks Club, Kiwanis, Shriner, Blue Lodge Knights Templars, D. A. V.'s, Veterans of Foreign Wars, the Jackson County Medical Society, Florida Medical Association and the American Medical Association. He was also a member of the First Baptist Church of Marianna.

Surviving him are his widow, Ruth Miller Hodges, and a son, Sanders.

The following information has been received from the Aetna Casualty & Surety Company, Atlanta, Georgia, through Mr. Paul F. Storrs, Special Agent at Jacksonville, Florida:

"Because of an unsatisfactory experience it has become necessary that we increase our Physicians' and Surgeons' Liability rate from $20.00 to $22.50 for certificates providing $5/15,000.00 limits. This increase became effective December 1, 1936, as to new business and January 1, 1937, as to renewal business."

* * *

The Pinellas County Medical Society is making elaborate preparations for the annual meeting of the Association, which will be held at the Vinoy Park Hotel, April 5, 6, and 7, St. Petersburg. An organization of committees is carrying on the preliminary work very efficiently. Next month's Journal will be the Convention Number and this issue will contain very interesting information concerning the coming meeting. Make your plans now to attend. You cannot afford to miss this meeting.

* * *

Dr. Kenneth Phillips of Miami has been notified of his appointment as American secretary to the Medical Association of the International Clinic. Representatives of the Association for 1937 include Dr. Clarence Neymann, Chicago; Dr. Pierre Vachet of Vienna; Dr. Gourliau, general secretary, Paris; H. L. Atwater, London; Dr. Phillips, Miami, secretary for America; Dr. Estaceny, secretary for France; Dr. Berardi, secretary for Italy; and Dr. Elder, secretary for Poland.

* * *

Dr. Frank L. Quillman, formerly of Winter Garden, is now full time county physician and health officer of Orange County. His offices are at 16 North Court Street, Orlando.

* * *

Dr. J. Harrison Hodges, of Gainesville, died February 3, following an illness of several weeks, at the age of 71. Doctor Hodges had been a member of the Florida Medical Association since April, 1890.

* * *

Dr. William J. Ebert of West Palm Beach, a member of the Palm Beach County Medical Society, died February 2, of coronary thrombosis.

COMPONENT COUNTY SOCIETIES

BREVARD COUNTY MEDICAL SOCIETY

The officers of the Brevard County Medical Society for 1937 are:

President—W. C. Page, Cocoa.
Vice-Pres.—G. E. Christie, Titusville.
Sec'y-Treas.—Bob Schlernitzauer, Rockledge.
Delegate—I. M. Hay, Melbourne.
Alternate—T. C. Kenaston, Cocoa.

The Brevard County Medical Society has reached the 100% paid class for 1936.

Dr. W. C. Page, the new president, accompanied the Association's business manager to Melbourne and called on a number of the doctors there in connection with county society affairs.

BAY COUNTY MEDICAL SOCIETY

The Bay County Medical Society has reported 100% of membership dues paid for 1936. This society has a membership of 12 doctors, located in Panama City and Millville. Congratulations, Bay County Society!

BROWARD COUNTY MEDICAL SOCIETY

The following officers have been elected by the Broward County Medical Society to serve for 1937:

President—G. S. McClellan, Pompano.
Vice-President—B. F. Butler, Hollywood.
Sec'y-Treas.—O. C. Brown, Ft. Lauderdale.
Censors—A. L. Elliston, H. J. Peavy, R. H. Stovall.
Delegates—Leigh F. Robinson, Elbert McLaury.

DADE COUNTY MEDICAL SOCIETY

The following committees have been appointed by the president of the Dade County Medical Society, Dr. R. N. Burch: Program—Milton Coplan, chairman; Kenneth Phillips, and E. B. Maxwell. Legislative—J. D. Milton, chairman; Edgar Peters, and J. C. Richardson. Economics—Marvin Smith, chairman; M. H. Tallman, and Frank Morrow. Milk Commission—Warren Quillian, chairman; C. L. Kennon, Sam Roberts, William McKibben, Rothwell Lefholz, and J. R. Perdue. Public Relations—J. D. Stewart, chairman; J. H. McClamroch, and Norton McKenzie.

The January meeting of the Society was held in the Woodard Addition of the Jackson Memorial Hospital, at which time a symposium on "Care of Surgical Patients" was heard. Dr. Walter C. Jones presented "Care of Surgical Patients," and Dr. M. Jay Flipse, "Medical Aspect of Postoperative Crises."

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular meeting of the DeSoto-Hardee-Highlands County Medical Society was held in Wauchula, January 12, with the following members present: McSwain, Highsmith, Eide, Spears, Chandler, Weems, McKnight, J. A. Simmons, Kayton, Poucher, Peacock, Kirkpatrick, Bevis and Martin. There were several visitors present among whom were Dr. W. M. Bevis of Mountain Home, Tennessee, guest speaker of the evening. He presented a paper on "Residuals of Jake Leg Paralysis," illustrated by moving pictures.

Mr. Blair of Lake Placid outlined a proposed advertising program for the treatment of snake bite, to be carried on in local newspapers. The president appointed Drs. Simmons, Peacock and Weems as a committee from the Society to confer with Mr. Blair and outline the course of treatment acceptable to the Society to be printed in local newspapers.

A vote of thanks was given to the Society members from Hardee County, who were hosts to the Society at dinner, penalty for having the lowest county attendance record for 1936. There being no further business, the Society adjourned to meet in Avon Park in February.

DUVAL COUNTY MEDICAL SOCIETY

The February meeting of the Duval County Medical Society was held on the evening of the 2nd, at the Seminole Hotel. A symposium on heart disease constituted the scientific program, the following papers being read: "Coronary Occlusion," Gordon Ira; "Valvular Heart Disease with Decompensation," E. C. Swift; "Lung Pathology in Cardiac Failure," L. S. Laffitte.

JACKSON COUNTY MEDICAL SOCIETY

At a recent meeting of the Jackson County Medical Society, the following officers were elected to serve for 1937:

President—C. H. Ryals, Grand Ridge.
Vice-President—D. A. McKinnon, Marianna.
Sec'y-Treas.—Lewis Pierce, Marianna.
Delegate to F. M. A. Convention—C. C. Box, Graceville.
Alternate—J. B. Dowling, Alliance.

The Jackson County Medical Society had a 100% paid membership in 1936 and have remitted two-thirds of their dues for 1937.

MONROE COUNTY MEDICAL SOCIETY

THE MONROE COUNTY MEDICAL SOCIETY IS THE THIRD SOCIETY TO REPORT 100% OF DUES FOR 1937 PAID. THE NEW OFFICERS OF THIS SOCIETY ARE:

President—HARRY C. GALEY.

Secretary—WILLIAM R. WARREN.

DR. WARREN WILL SERVE AS DELEGATE TO THE NEXT ANNUAL CONVENTION OF THE STATE ASSOCIATION.

ORANGE COUNTY MEDICAL SOCIETY

The Orange County Medical Society held its annual banquet at the Dubsdread Country Club on January 20.. The meeting was well attended and enjoyed by all. Drs. C. D. Christ and J. S. McEwan were the principal speakers. They recalled interesting events in the original meeting for the organization of the society more than twenty years ago.

The annual banquet held at the January meeting each year without a program has become an institution, having been the custom for many years. This is an occasion when nearly all of the members come together for an evening of good fellowship and a rousing good time. It is the time when worries are laid aside and the fellows get closer together and form closer ties for the ensuing year. A bountiful repast with a flowing tide of good cheer, free songs, recitations of poetry and verse, when minutes are as hours, and hours are as minutes—well, "It's always fair weather when good fellows get together." It is the one glorious meeting of the year for the Orange County Medical Society.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The Pasco-Hernando-Citrus County Medical Society met in Brooksville, January 15. Dinner was served at the home of Dr. and Mrs. G. R. Creekmore, followed by the scientific meeting at the Hernando County Hospital.

Dr. P. J. Hudson of Crystal River presided at the scientific meeting. Guest speakers for the occasion were Drs. James L. Estes and H. O. Brown of Tampa. Dr. Estes presented a paper on "Diagnosis and Treatment of Renal Calculi" and Dr. H. O. Brown of Tampa led the discussion and showed a number of x-ray films. Dr. Ralph T. Heath of Brooksville was elected to membership in the Society. The annual election of officers was then held, with the following result:

President—W. Wardlaw Jones, Dade City.

First Vice-President—S. C. Harvard, Brooksville.

Second Vice-President — George A. Dame, Inverness.

Sec'y-Treas.—G. R. Creekmore, Brooksville.

Board of Censors—J. T. Bradshaw, San Antonio, for Pasco County; A. C. Coogler, Brooksville, for Hernando County; P. J. Hudson, Crystal River, for Citrus County.

Dr. S. C. Harvard was elected delegate to the State Association meeting and Dr. W. Wardlaw Jones, alternate.

It was decided to hold the February meeting at Crystal River, with Dr. P. J. Hudson as host.

PINELLAS COUNTY MEDICAL SOCIETY

At the meeting of the Pinellas County Medical Society, held January 15, Dr. C. C. Rudolph presented a very interesting paper on "Pediatric Fallacies." He exposed common fallacies regarding teething, worms, calomel, colic, constipation and diet. Mr. Meigs spoke on "Union Service."

The first meeting of February was held February 5 at the Shrine Club. Dr. L. B. Mount was principal speaker. He read a paper on "Pruritis Without Skin Eruption."

POLK COUNTY MEDICAL SOCIETY

At its annual election of officers held recently, the Polk County Medical Society chose the following officers for 1937:

President—R. E. Gilbert, Winter Haven.

Vice-President—S. A. Lindsay, Ft. Meade.

Sec'y-Treas.—(for 6th year)—J. R. Boulware, Lakeland.

Censor—(for 3 years)—W. T. Simpson, Winter Haven.

PUTNAM COUNTY MEDICAL SOCIETY

THE PUTNAM COUNTY MEDICAL SOCIETY BECAME THE SECOND SOCIETY 100% PAID FOR 1937. CONGRATULATIONS! HEADING THE SOCIETY FOR THIS YEAR ARE: J. H. JOHNSON, PRESIDENT, AND F. EMORY BELL, SECRETARY.

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P. O. Box 9,

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Inasmuch as I am still out of Florida, though on my way home, and because no mail has reached me this month from Auxiliaries, this can't be a news letter of Auxiliary activities. It must of necessity be a travelogue, personal column, or what have you. But since this week has seen me cavorting over the country on a roundabout return to Florida, in connection with work that should interest every doctor's wife, surely you won't mind if I call this "A Doctor's Wife Looks at Life."

Before leaving Philadelphia, I did have contacts with Mdmes. Doane, Odenatt, and Wilkinson of the Philadelphia Auxiliary, though I was unable to attend a meeting of the Auxiliary as planned. This one county auxiliary has more members than our whole state auxiliary and when Mrs. Doane, an intimate friend, was president of the Philadelphia Auxiliary and I was state president in Florida, it was a standing joke of ours that though I outranked her as far as position went, she certainly outnumbered me in membership.

The Philadelphia Auxiliary does many fine things but its outstanding activity each year is its Health Institute. There are not many of its activities that we are able to copy but this Health Institute is one thing that every county auxiliary in our state could handle to great advantage. It is an all-day meeting to which all women's organizations in the county are invited and the program is made up of talks on health subjects by recognized authorities, followed by discussion. A program of this type is given every year and the women tell me that the response is splendid. Let's keep this in mind for next year and maybe we can work out a schedule throughout the state. If you are interested, write to me about it, for there is still time to do something this year.

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Now our scene shifts to Memphis, Tennessee. The date is January 25th (the date on which this copy should have reached the Journal) and I am attending a meeting of State Commanders of the Women's Field Army of the American Society for the Control of Cancer. This is a meeting for the Southern States and in spite of flood conditions, ice storms, etc., a woman from each of eleven states was present, a 100% attendance. Presiding over the meeting were Mrs. Grace Morrison Poole, Chief Adviser, and Mrs. Marjorie B. Illig, organizer, and present with us were Drs. Goldstein of Arkansas, Herbert and Munger of Tennessee, and Cox, who is Field Representative in the South for the Society. It did my heart good to see the encouragement which these men received from the interest and enthusiasm of these women. Even Dr. Cox who knows better than any one the effort which our campaign is going to take, was happy when the meeting was over.

Four of the women in attendance were doctors' wives, and three of us have been active in Auxiliary work. You will be interested to know that the immediate past president of the Auxiliary, A. M. A., Mrs. Rogers N. Herbert of Tennessee, is Commander for her state, and our present First Vice-President of the Auxiliary, A. M. A., Mrs. David S. Long, represents Missouri. Mrs. Palmer of Illinois was the other doctor's wife in addition to your humble servant.

Now if these women who have given so much of themselves to Auxiliary work can feel the call to work in this great campaign of "Fight Cancer With Knowledge," can't you as Auxiliary members do your bit? So please think of this, when I begin to write letters to you next month and ask your assistance in carrying on this work in Florida.

No, I didn't get caught by the flood in Memphis. I am now on the top of Lookout Mountain, high and dry, but I did see the refugees in Memphis, and I am appalled by the radio bulletins to which we listen all day. I am sure that you, too, have listened in and have done your bit to help.

I am here for only a few days to see my boy who is in the McCallie School, and I will be home long before you read these lines. So please take notice, publicity chairmen, and send in your accounts of Auxiliary activities so they may be published next month.



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SUMMARY OF JANUARY ISSUE

Recent advances in nutrition with particular reference to infant and child feeding are ably summarized in the article outlined in Abstract No. 1, in which the needs of infants for high protein, the advantages of lactose as a carbohydrate, and the value of milk as a source of assimilable calcium are among the various topics discussed.

In the extensive survey of foods that disagree with healthy persons, which is reported in Abstract No. 2, it was found that milk and cheese are very infrequent offenders.

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honey for twelve weeks maintains and promotes good health in man, according to the study reviewed in Abstract No. 3.

In the dietary treatment of chronic arthritis, high protein foods such as milk, eggs, and meat are recommended, as shown by the article which is the basis of Abstract No. 4.

The dietetic management of diabetes is discussed in Abstract No. 5, from which it appears that milk and butter play a prominent role in the treatment of this condition.

Cheese is an excellent source of lactoflavin, or vitamin G, as indicated by the experiments reported in Abstract No. 6.

An editorial on food poisoning, reviewed in Abstract No. 7, mentions the value of pasteurization of milk and refers to the absence of botulism in our commercially canned foods.

Undulant fever, which is widespread in Texas, is preventable by means of general pasteurization of milk, according to Abstract No. 8. A formidable list of epidemics in Canada due to unpasteurized milk is presented in Abstract No. 9, together with a plea for more universal pasteurization.

Successful use of sweetened condensed milk for twenty years in a French clinic is divulged in Abstract No. 10.

A new digest of scientific literature on the nutritive and therapeutic values of the banana is the subject of a review in Abstract No. 11.

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Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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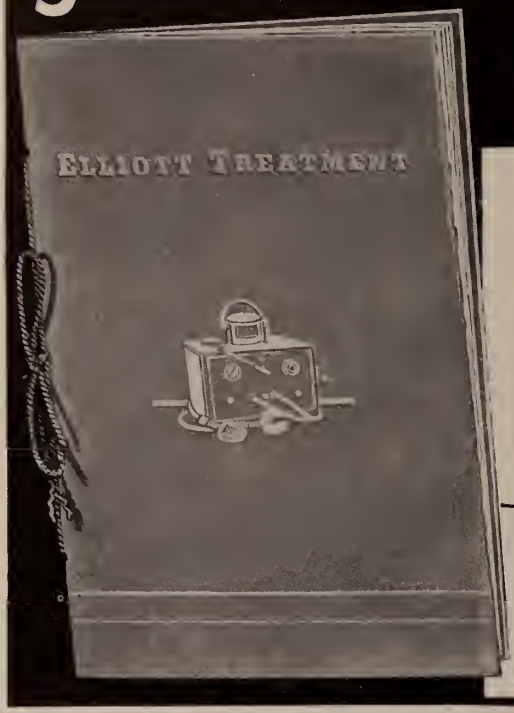
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COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville		
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville				
Brevard	W. C. Page, M.D., Cocoa	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	3	30%
Broward	George S. McClellan, M.D., Pompano	Oliver C. Brown, M.D., 915 Sweet Bldg., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale		
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City		
Dade	R. N. Burch, M.D., 1774 S.W. Eighth St. Miami	Walter C. Jones, Jr., M.D., 802 Huntington Bldg. Miami	1st Friday 8:30 P.M.	Elks Club		
DeSntn-Hardee-Highlands	Gordon H. McSwain M.D., Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	19	100%
Duval	Kenneth A. Morris, M.D., 237 W. Duval St. Jacksonville	George W. Croft, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	68	43%
Escambia	J. C. McSween, M.D., Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola		
Hillsborough	George L. Cook, M.D., 443 W. Lafayette Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa		
Jackson	C. H. Ryals, M.D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	11	73%
Lake	LeRoy H. Oetjen, M.D., Leesburg	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 P.M.	Eustis	10	63%
Lee	H. Quillian Jones, M.D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M.D. 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers		
Leon-Gadsden-Liberty-Wakulla-Jefferson	L. L. Dozier, M.D., Tallahassee	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies		
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			4	100%
Manatee	S. G. Hollingsworth, M. D. 451 12th. St. Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton		
Marion	Ralph E. Russell, M.D., Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	21	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	3	100%
Orange	F. H. Harms, M.D., 64 No. Court St. Orlando	Hewitt Johnston, M.D., Box 2002 Orlando	3rd Wednesday 8:30 P.M.	Varies		
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Nettn, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	25	45%
Pasco-Hernando-Citrus	W. Wardlaw Jones, M.D., Dade City	G. R. Creekmore, M.D., Brooksville	2nd Thursday 7:00 P.M.	Varies	3	21%
Pinellas	N. M. Marr, M.D 812 Power & Light Bldg., St. Petersburg	W. C. McConnell,, M. D. 1005 Equitable Bldg. St. Petersburg	1st. and 3rd. Friday 6:30 P.M.	Shrine Club St. Petersburg	47	55%
Polk	R. E. Gilbert, M.D., 19 Postal Arcade, Winter Haven	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb. April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland		
Putnam	H. A. Johnson, M. D. Palatka	F. Emory Bell, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Johns	Charles C. Grace, M.D., East Coast Hospital St. Augustine	R. D. Harris. M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	8	73%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies		
Sarasota	Arthur O. Morton, M.D., Commercial Court Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies		
Seminole	J. T. Dentn, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford		
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies		
Taylor	J. C. Ellis, M.D., Perry	J. L. Weeks, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry		
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Walton-Okalnosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M	Varies		

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The JOURNAL of the Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XXIII
NO. 9

Jacksonville, Florida, March, 1937

Yearly Subscription, $3.00
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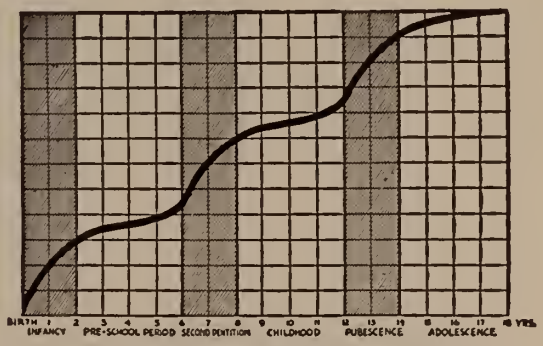
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Vitamin C intake of this order of magnitude prevents the development of clinical scurvy, however, it is probably inadequate for optimum nutrition. Clear cut cases of scurvy seldom are seen in this country although some authorities believe that symptoms of a mild deficiency of vitamin C are not uncommon (2).

Referring to nutritional deficiency diseases in general it has been said that, "Almost every tissue in the body may be affected by a deficiency in a food factor" (3).

The tissues generally recognized as affected by deficiency of vitamin C are the endothelium of the blood vessels and the teeth. It has been suggested that to prevent the development of subclinical symptoms, a daily intake of 380 to 540 International units of vitamin C is required for a 130 pound adult (4).

Thus it would appear that the optimum intake of vitamin C is at least twice the amount required to protect against scurvy.

Data recently published demonstrate that the vitamin C content of human milk is dependent upon the vitamin C content of the maternal diet (5).

Hence when the diet of the lactating mother is low in vitamin C, this factor is also deficient in the milk.

The League of Nations Technical Commission recommends an intake of over 500 International units per day during pregnancy and lactation (6).

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(1) 1934-35. Am. Pub. Health Assn. Year Book. Page 71
(2) 1933. Chemistry of Food and Nutrition. H. C. Sherman. 4th Ed. Page 421 MacMillan, New York
(3) 1936. J. Am. Med. Assn. 106, 261
(4) 1934. Nature 134, 569
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(6) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.
(7) a. 1925. Ind. Eng. Chem. 17, 69
b. 1928. Ibid. 20, 202
c. 1933. Ibid. 25, 682
(8) a. 1935. J. Nutrition 9, 667
b. 1936. Ibid. 11, 383
c. 1936. Ibid. 12, 405

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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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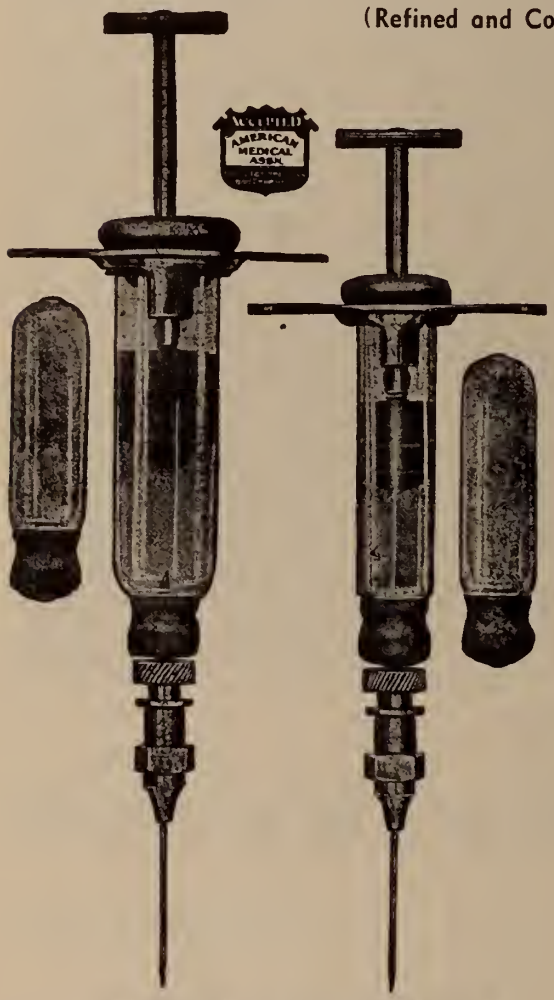
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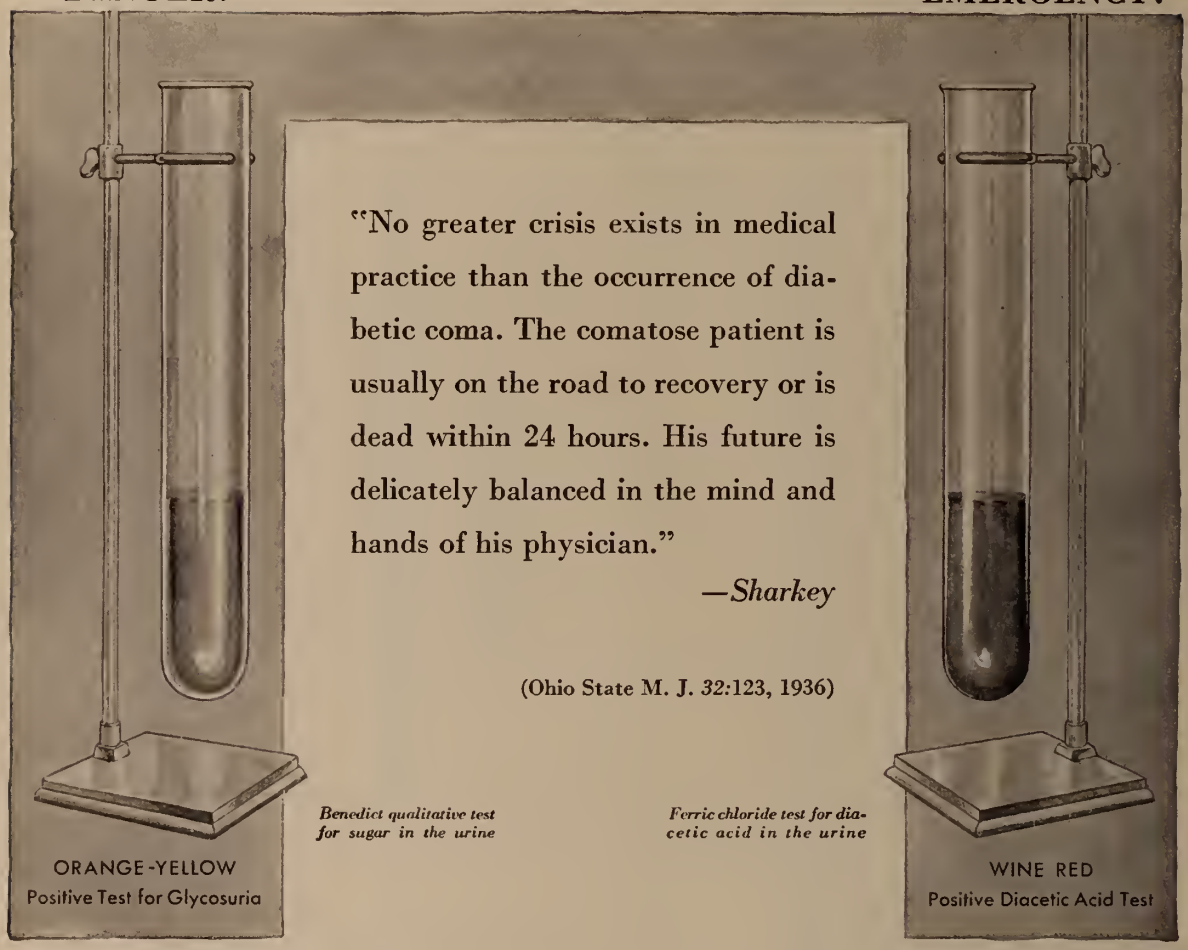
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXIII Jacksonville, Florida, March, 1937 Number 9

THE TREATMENT OF ERYSIPELAS BY ULTRAVIOLET RAY*

ANNETTE M. BIEKER, M.D.,
St. Petersburg.

Erysipelas has been recognized as a clinical entity for many centuries, but its contagious nature received no attention until about 1850 when this was noted by English writers. In 1883, Fehleisen of Berlin described the specific organism, streptococcus erysipelatis, and later research confirmed his description. The disease has been called, descriptively, "The Rose", and "St. Anthony's Fire."

It is endemic in all countries, and the symptoms are sufficiently clear-cut to make the diagnosis easy in the majority of cases. It is an acute inflammatory disease of the skin, characterized by redness, heat, swelling, a shiny appearance of the skin, a raised irregular palpable margin, and sometimes by vesiculation. Loose tissues become swollen. The onset may be heralded by chill, anorexia, and headache. The temperature may be slight or quite high. Pulse and respirations are rapid. The process begins to clear in the center while the edges are still active. The organisms are found in the skin, but in virulent cases may be found in the blood also. Lymph nodes draining the area are usually enlarged. Superficial gangrene may occur, if the vesicles are ruptured. Complications may be abscess, septicemia or pyemia, pericarditis, suppurative arthritis, adenitis, otitis, or meningitis. There is usually albuminuria. The incubation period is usually three days, but may vary from two to eight. Ninety per cent of all cases are facial; eight per cent occur on the leg.

The extremes of life show a very high mortality. Of untreated infants, 60% to 90% die. The disease is more malignant and toxic in infants, and the tendency to suppuration is greater. There is apparently, however, some tendency in children to develop immunity, which is not the case in the adult.

The treatment of erysipelas has progressed through several stages. Years ago, local applications of wet dressings, various counter-irritants, painting with iodine, collodion, etc., were the only available measures. With the advent of erysipelas antitoxin, a marked reduction in mortality and morbidity came about. The x-ray has been used with a fair measure of success. For both serum and x-ray therapy much may be said, but both have the disadvantage of being to a certain extent (certainly in unskilled hands) dangerous, more expensive, and less certain.

The application of ultraviolet light in the treatment of erysipelas is no recent innovation, as it has been used in various parts of the world for over 20 years. In contemplating the effect of various forms of radiant energy upon the body, it must be remembered that this energy is not lost when the rays are stopped. Depending upon the wave length of the rays, either thermal or chemical changes occur, and the biological effect is due to the tissue reaction to these changes. The depth to which various wave lengths penetrate is interesting in calculating the effect of light treatment. Ultraviolet rays with a wave length of from 2,000 to 2,400 Angstrom units (1 Angstrom unit equals one ten-millionth of one millimeter) are stopped in the stratum corneum of the epidermis. Those with a wave length of 2,500 to 3,300 pass through this layer but are stopped in the stratum mucosum; those from 3,400 to 3,900 Angstrom units pass through the epidermis, but are stopped by the blood in the subepidermal capillaries. Glass absorbs all rays shorter than 3,300 Angstrom units, while quartz absorbs those shorter than 1,800. As for the bactericidal activity of light rays, Bovie has shown that the wave lengths below 2,800 are most destructive. This is well within the range of the quartz rays, but the slight penetrating power of these rays restricts the direct bactericidal potency in skin infections. The effect, therefore, of ultraviolet rays in erysipelas is probably not a germicidal action. This has been demonstrated by Titus,[1] who found that even though a portion of the inflamed skin and margin was covered during treatment, the lesion did not progress. He therefore concluded that while the exact mode of action of the light is undetermined, its effects may be explained as chemical

*Read before the Pinellas County Medical Society, June 19, 1936.

effects on certain proteins, either of the tissues, or the nucleoproteins of the bacteria. He suggests four modes of action:

1. Increase in local resistance to the sensitizing action of the bacteria.
2. Effect of the energy of the nucleoprotein of the bacteria, not sufficient to be classed as germicidal. (Quartz rays are only slightly absorbed by the cytoplasm, and are strongly absorbed by the nucleus.) This effect was demonstrated by testing a patient susceptible to a certain strain of streptococcus with nucleoproteins of the same bacteria which had been treated with ultraviolet rays; to this no reaction was shown.
3. The superactivation of phagocytes.
4. Local inflammation and continued counter-irritation through the effect of the erythema. The burn kills some epithelium, not all of which is cast off. The histological effect is primarily a degeneration of the prickle cells. Absorption of the toxins from these may cause an accumulation of red and white cells in the radiated area with a dilatation of the capillaries. Since there is no pus formation, the leukocytosis probably does not directly influence the infection. A transudate of serum from the edema may act as an auto-antitoxin.

All these suggested modes of action disregard bactericidal effect in vivo, and practically all effects can be attributed to oxidation.

It may be noted in this connection, however, that the superficial bactericidal action is sufficiently pronounced to render it safe to allow cases of erysipelas to remain in wards with other patients. Devine[2] reports that in ten years' experience with ultraviolet therapy in erysipelas in the Veterans' Facility in Whipple, Arizona, there has been no spread from any case, and in the Presbyterian Hospital[3] in New York cases are allowed to remain in the wards, and are taken off infectious precautions in 48 hours.

The effect of ultraviolet light on the patient with erysipelas is sufficiently marked as to be somewhat spectacular. The beginning of improvement in the patient coincides with the development of the erythema, which occurs in from two to eight hours following treatment. Relief from discomfort, drop in temperature, and limitation of spread of the lesion may be expected from the first exposure, provided the dosage is sufficient. This is one form of therapy in which conservatism in dosage has no place. In view of its high mortality rate the disease must command our respect, and heroic dosage is in order. The dosage varies with the age and make of the lamp, the age, coloring and degree of tanning of the patient, and the location of the lesion. The aim should be in every case to produce the desired erythema, which is just short of vesiculation, at the first treatment. When this is done a second or third exposure is often unnecessary. Most patients, when this is satisfactorily explained to them, will gladly submit to the minor after-effects of a severe sunburn without complaint. Only experience and strict standardization of the lamp in use enable one to calculate the exact dosage in every case, but the danger is in caution, rather than in overdosage. Even a blister, while uncomfortable for a time, is not dangerous, and as compared with some of the untoward after-effects of serum administration, is a minor incident. If, therefore, there is any question as to the exact dosage, over treatment rather than undertreatment is to be preferred. If a satisfactory erythema has not developed within twelve hours after the first exposure, treatment may be repeated at this time to produce the desired degree of reaction. If, within 24 hours, there has been any extension of the lesion, or if the temperature has not dropped satisfactorily, the dose is repeated, and this is continued at 24-hour intervals for as long as may be deemed necessary. A margin of two inches of healthy skin around the lesion is treated and the surrounding area protected by towels or black paper. The most virulent portion of the lesion is at the edges. In facial cases the eyes are usually protected by a narrow strip of wet cotton along the margin of the lids. The edema of the lids, which develops in most cases, is probably due to the disease and not to the light; since it has also been observed in cases treated with x-ray. More difficulty is experienced in preventing extension of the lesion in cases where the process has crossed the hair line, and to those extending into the external auditory canal than in any other types, due to the fact that ultraviolet light does not penetrate hair, and to the practical impossibility of introducing the light into a canal with the walls swollen tightly together.

In the average case of moderate severity one treatment is often sufficient. In a comparative study of 402 cases, using wet dressings, ultraviolet, x-ray, and antitoxin, Ude and Platou[4] of Minneapolis report that in 92% of cases treated with ultraviolet, clinical arrest of symptoms followed one treatment. Sutherland[5] of London, reporting 90 cases, gave one treatment in 60 cases, and averaged two treatments for the series. He reports the average hospital stay cut from nine days to five days. Lavender and Goldman[6] found that in a comparative series, 32 cases receiving antitoxin required an average of 4.8 injections of serum, while 26 cases on ultraviolet required three treatments each. Nightingale and Starr,[7] reporting on results of ultraviolet treatment exclusively in 51 children under twelve at King's County Hospital, New York, give a routine of three treatments. Titus reports an average of 1.9 treatments in 29 cases. Among the earlier writers, Petenyi[8] of Germany in 1921 reported a series of 14 infants, treated two to three times each, with complete success in 85%. A large number of reports have been made, many of the series small, but the satisfactory results are too consistent to be accidental.

To the cases already on record I wish to add a report of twenty cases. Of these nine were facial, four had involvement of the arm, six of the leg, and one the back of the neck. The number of treatments averaged two and one-third. I shall not bore you with detailed case reports. The ages varied considerably. No case has been included in which there was any doubt as to the diagnosis. A number of erysipeloids have been treated, with completely satisfactory results. My average as to number of treatments was raised considerably by one case in which abscess formation complicated the picture, and by two cases in which the auditory canal was involved. The two latter cases were each given one dose of antitoxin, because, although symptoms had subsided considerably, a persistent low-grade temperature suggested that the extension into the ear might not be under complete control. In another case there was a recurrence after some weeks; both attacks were controlled with one treatment. In thirteen cases two treatments were given. These had marked improvement after the first, and complete cure after the second treatment. Altogether, the results have proved highly satisfactory to everyone concerned.

CONCLUSIONS

The ultraviolet ray seems to be the treatment of choice for erysipelas, from the standpoint of rapid control, safety, and economy to the patient. It shortens the period of hospitalization, eliminates the necessity for isolation, and has considerably lowered the mortality rate. The optimum dosage is just short of vesiculation.

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PRURITUS WITHOUT PRIMARY SKIN LESIONS*

Louis B. Mount, M.D.,
St. Petersburg.

It may seem trivial and academic to discuss, before a group of physicians, a subject so common as itching. It may even appear to be a waste of time on the part of both the listeners and the essayist. But think of the havoc some of us have seen brought about by this symptom—yes, even suicide.

The doctor brought face to face with pruritus is often at his wits' end as to the causation and treatment of this disagreeable phenomenon. Such a statement might imply that it is my intention to be dogmatic, but that is furthest from my mind. Neither is there any intent to be iconoclastic. Socrates, I believe it was, said that the beginning of wisdom was to know nothing. He who would ascribe a symptom to one cause only in each and every case is a fool. The faddist has no place in the practice of the ancient art of medicine, an art which requires all the tact and

*Read before the Pinellas County Medical Society, February 5, 1937.

resourcefulness at one's command. He is worse than useless.

Of all the subjective symptoms encountered in diseases of the skin, itching is by far the most common, and the skin disease is most uncommon which at some time or other during its course does not present pruritus in the foreground. It has the same relationship and meaning to the dermatologist that pain has to the internist or to the surgeon. The very significance and diagnostic import of this symptom is too often entirely overlooked. The pruritic wandering from pillar to post, trying all the panaceas advocated by his well-meaning friends, complaining bitterly of his lot and often cursing it, seeks the aid of his physician, looking upon him as a beacon in the fog, only to be told, "Oh, forget it, it is simply nerves." Is it any wonder that charlatanism and the various healing cults prosper?

Such advice as "oh, forget it" can and should be given only after a most complete examination and only after all possibilities as to its causation have been thoroughly investigated. This in itself instills confidence in the patient, and he who said that confidence is half the cure spoke not far from the truth.

Pruritus is a paresthesia and may be defined as a disturbance of the nerve elements of the skin. It is an anomoly of feeling, not dependent primarily upon local lesions or changes or local irritations, and not denoting any increase or decrease of the normal sensations. A physiological pruritus is described by Jacquet. He says that in our normal life we have a slight degree of consciousness of our skin. There is a feeling of touch, of temperature, of pain, etc. There are constantly varying sensations present from our contact with things about us, for example, light, air, our clothing. Who, on removing his clothing at night, does not scratch? Jacquet claims that an itchy area is in a state of prurigenous hyperesthesia and that following a prolonged scratching it goes into a state of hypoesthesia. This explains why so many of our patients tell us: "Doctor, the only relief I can get is by giving the itchy area a good scratching. Then it lets me alone for a while."

The etiological factors producing itching of the skin may be divided into internal and external. The internal may occur in either of two ways, by means of the nervous system or through the blood or lymph. Of course it is well understood that in every case the nerves are affected. Are the nerves the primary cause or are they involved secondarily because of other conditions in the human economy which in some way so alter the blood or lymph as to produce nerve irritation? This is the important question to be solved.

The nature of the nerve affection may be either organic or functional. The latter is of great significance because pruritus is linked up, to an astonishing degree, with psychic events. Here it is possible to study the powerful effect which the psyche exerts upon our sensations. The force of suggestion and especially of autosuggestion comes to light. We see a mosquito, a flea, a louse or any other itch exciting skin parasite; immediately we feel itching. Every physician whose clientele does not dwell on the gold coast, and even among these fleas and pediculi are not rarities, has himself experienced momentary pruritus occasioned by looking at a patient infested with vermin. But, we can go a step farther. We don't even need to see the parasite; the mere thought of an itch sensation is enough to arouse it. So we have the reason why this discussion of pruritus is in itself enough to forcibly cause us to scratch. I want you to understand explicitly that this psychic influence does not show itself in hypersensitive individuals alone. Every one is subject to it. It becomes morbid only in the hysterical and yet it is of great purport in every pruritic affection.

This dependence upon the psyche must be borne in mind therapeutically because it is sufficient to keep out of the patient's consciousness the fact that healing has already been accomplished. Granted that the sickness causing the itching has been cured, the pruritus may still torment the patient. He fears it, he thinks about it, he broods over it; in fact, it becomes the all-possessing idea and that is sufficient through psychic means to keep up the paresthesia which was set loose by somatic disturbances removed by this time. A single case report exemplifies clearly the part that the psyche plays even though the original skin lesions had disappeared.

Mrs. A. C., aged 36, consulted me about a very extensive erythematous eruption involving most of the body surface, and accompanied by an intense pruritus. The latter became so severe that the patient was put to bed. Under appropriate treatment, the eruption disappeared in about ten days, but she still complained bitterly of the itching. In fact, she stated that she could

not stand the contact of her clothing and so remained in bed, even keeping the sheet from her body by means of a wire frame. After this had gone on for several days, the husband was moved into the attic with directions that he was not to appear on the scene no matter what occurred. The sympathetic nurse was discharged and a tyrant put on the job. She insisted that the patient get out of bed or she would pull her out. The clothes were put on forcibly and the patient taken for a walk even though there was considerable moaning and sobbing. Suffice it to say that a comparatively few days of such treatment brought about a cure, impossible of achievement in any other way.

We must be keen enough, whenever possible, to charm away the suggestive influence by suggestion as well as by a firm assurance of the cure. The ups and downs of self-attentiveness play a big role in all pruritics, certainly as long as the cause continues and the affliction is in full bloom. As miserable as the sensation of itching is, just so easy is it, with the exception of very malignant cases, to suppress it through either the mental activity of an absorbing occupation or by means of the substitution of some other sensation such as pain. In this way we find the afflicted forgetting about his itching as long as he is busily engaged only to complain bitterly when he is idle. We notice also that the pruritus vanishes when, through whatever means, pain appears. Hyperalgesia dispossesses the paresthesia. It causes a deeper imprint on the nerve substance. These facts are of much value therapeutically. We strive to prevent by mental diversion the itching from reaching the perception. We make use of the sense of pain and through burn exciting agents cover up the pruritus. To the pure psychic causes and melancholia, as sources of itching, must be added the so-called functional neuroses, hysteria, neurasthenia, chorea, etc. The first two are fortunately not often itch excitors. A purely hysterical pruritus is rare but when it does happen it is very bad.

Sometimes itching of the skin is due to organic changes in the central nervous system. The central seat of pruritus is probably in the cortex of the brain. Cases are known where the first manifestation of tumors in this location has been itching. Various central organic conditions have had pruritus associated with them. In 1885 Joseph reported a case of unilateral pruritus secondary to a cerebral embolus. Fortunately, such an association is rare. It can be stated also that a not very great role is to be ascribed to diseases of the peripheral nerves, but reflexes by way of the nerve paths are not uncommon. There are undoubted cases of internal diseases which produce itching at distant areas even though no knowledge is possessed of how it is brought about. These are unfilled gaps in medical erudition and such cases are spoken of as "reflex origin," a term so often used to express our ignorance. Pure anogenital pruritus, and by this is meant the complete absence of objective dermal lesions, is frequently cured by the removal of some pathology in the abdominal or pelvic cavity.

In itching by way of the hematogenous route, there must be in the blood stream changes which alter the nerve endings in the skin, either the corpuscles of Vater and Meissner and the end knobs of Kraus or the free, fine, non-medulated fibrillae. These changes in the blood can be of various kinds:

1. The relationship between the number of red and white cells may be varied, a change often causing itching without any lesion of the skin, for example, the leukemias, lymphosarcoma, pernicious anemia and Hodgkin's disease. Zeigler in his monograph on Hodgkin's disease states that pruritus is the first clue in a large percentage of the cases and might be noticed months before any other sign of the disease. This was exactly what occurred in a case in which the narrator was called in consultation. The patient, a well-developed female of 40, had been suffering from in intolerable itching on various areas of her skin. There were no primary lesions. No glandular enlargement could be found. The blood showed a mild secondary anemia. A search for intestinal parasites was made even though no eosinophilia existed. There were periodic rises in temperature which lasted for a few days. After her distressing condition had existed for several weeks, and due to the feeling which both her physician and I shared that there was some pathology in her abdomen—we thought we could make out a tumor—an exploratory section was done. The mesenteric glands were found enlarged. One was removed and the microscopic changes found therein were those of Hodgkin's disease. In pernicious anemia, a peculiar symp-

tom sometimes noted is pruritus localized to the tongue, especially to the sides. This is often accompanied by burning and even pain and may be the first subjective symptom.

2. More frequently the change in the blood stream is in the nature of some toxic ingredient introduced by way of either the digestive tract, the respiratory apparatus, or subcutaneously by the hypodermic route. Under this heading comes the strange phenomenon of itching following the use of opium. Who isn't familiar with the generalized itching following a dose of morphine. In the same category belong many of the coal tar products, the various barbituric derivatives, phenolphthalein, salicylic acid, etc., also many drugs derived from plant life such as belladonna, and quinine; also the heavy metals, bismuth, mercury and arsenic. Pruritus is often the first indication of an arsenical intoxication, and in using the various arsphenamines, prior to each treatment, inquiry should be made as to the presence or absence of itching. If physicians would give heed to this timely warning signal, it might be possible to avoid many of the tragic happenings, arsenical dermatitis, atrophy of the liver and death. The knowledge that alcohol produces pruritus often comes in very handy. Jacquet in 1904 fully described this in his masterful essay on pruritus in La Pratique Dermatologique.

3. Some of the harmful products of perverted metabolism gain entrance into the blood. Conditions belonging to this group are hyperglycemia, uricemia, uremia, liver diseases, gall-bladder affections, and intestinal autointoxication, if the latter really exists.

4. Allergy now, in place of the time-honored eczema, is the dermatologic waste basket into which everything is thrown when no other cause can be discovered. The poor old allergens are being blamed for all the sins of Satan. Scratching and patching is fast becoming a mania. Let us be sane. I grant that such procedures are justifiable and even called for under certain conditions, but don't let the pendulum swing so far to the left that it can never return to the mid-point.

Lastly there is a large group of cases in which the pruritus is due to a susceptibility of the skin to some external excitant. This excitant may be of the most varied type, for instance, a puzzling recurrent pruritus of the left cheek due to the wearing of a boutonniere, in this case an aster; the localized itching of the neck in the female sex due to exposure following shingling and bobbing of the hair; a pruritus of the face coming each week and finally found to be caused by a susceptibility to the colored sheet of the Sunday newspaper; the itching due to face powders, perfume itself or the odor of the latter. In the modern household a single bathroom is a rarity. Homes of any size have two or more, so they are made use of frequently, in fact too frequently for the welfare of the bathers, who soap and scour themselves once, twice or more times daily. With them, bathing, ordinarily laudable, has become a mania. This is all very well for those with an excessively oily skin but the average individual, especially if he has a rather dry skin, is desiccated. The little lubricating oil poured out by beneficent nature to protect man's external covering is removed; nothing is put back to replace it and itching ensues—bath pruritus.

One type, frequent in occurrence, deserves special mention. This is anogenital or anovulvar pruritus. Here we are dealing with one of the most intolerable symptoms encountered by the physician. Starting with no objective lesions, the patient causes extensive cutaneous thickening and inflammation because of the almost constant scratching. The tissues become leathery, whitened and soggy in appearance and show long, deep, red grooves where the patient has denuded the outer skin in the agonized attempts at relief. Many of us have seen hysterical crises as the result of such attacks. It is not uncommon to find the clothing or underclothing literally worn through from the constant rubbing. In many of the anal conditions a concomitant or following fissure with a tendency to mucous discharge may keep up the affection. Again, hemorrhoids, either internal or external, may be of some import. One of the commonest conditions, however, is a secondary trichophyton infection. This adds an extra load to the sufferers, already almost unbearably burdened. In many of the scrotal cases absolutely no causation can be found, while in pruritus of the vulva, irritating discharges, gynecological conditions or sugar in the urine may have a direct relationship. Unfortunately, such a relationship can not be demonstrated in every case as the following report will disclose:

Mrs. F., aged 42, developed an anovulvar pruritus. Her health, otherwise, was very good and

there were no other complaints. All methods of therapy, x-ray, local applications, bromides and various hypnotics and analgesics were of no avail; even a sacro-caudal block with novocain gave only a short interval of freedom from the intense irritation. All attempts to find a cause for the ever increasing pruritus were fruitless. Finally, under ether anesthesia, the skin of the entire involved area was undermined. Gauze with vaselin was drawn through slits in the skin and left there for a few days to prevent apposition of the undermined skin. This surgical procedure gave immediate relief with no subsequent return of the itching.

The causal differential diagnosis depends much upon the type of pruritus. With a localized case, one certainly must seek an external irritant as the excitant. With a process involving the vulva or anus, fissures, hemorrhoids or gynecological conditions must be excluded. Failure to examine the urine is inexcusable as is also the failure to search for body parasites. With the generalized type, the causation may be drugs, one of the lymphomas, diabetes, focal infection, uricemia, or one of the variety of excitants which can be differentiated only by a careful study of the body liquids and the blood. It may be necessary to remove a gland for microscopic study. The recognition of bath pruritus is fairly easy as there is the dry skin and the history of frequent bathing. In the uricemic cases there is often an association with rheumatism, neuralgia, migraine, etc. The neurogenous patients usually show an increase of calcium as well as of sugar and urea in the blood stream. Senile pruritus has not been touched upon at all because it should offer no diagnostic difficulties.

All the diseases of the skin with demonstrable primary lesions, accompanied by pruritus, as well as the various means and methods of treatment, have been left out of this discussion purposely. In this brief and probably sketchy survey, the attempt has been made to show the multiplicity of agents causing itching and the perplexity of the problem.

Acknowledgment to the rather free use of the many excellent articles and monographs on the subject is hereby made. Without them much material of great value would not have been touched upon.

THE PROGRESS OF MEDICINE*

Alvin J. Wood, M.D.,
St. Petersburg.

Medicine, like time, marches on. Time has made changes in medicine; the evolution has come in waves of progress and depression. Medicine is among the older professions and has kept pace, if not surpassed, all others in progress.

The first outstanding progress was made about the year 400 B. C., during the time of Hippocrates. He contributed so much, laying the foundation for the medical profession, that he is called the Father of Medicine. He described some diseases so accurately that little change has been made up to the present time.

It is not my purpose to point out the great leaders of medicine through the ages so much as to show the progress made by the profession as a whole. Many have left footprints that will never be erased. Some received credit; others did not. Many who contributed were forgotten a short time after death. Proper credit cannot always be given by historians but, as time goes on, we can look back without prejudice, giving credit to those who made lasting contributions.

The average age of life has been greatly extended during the past thousand years. According to one statement I found, the average length of life in the 13th Century was eight years; today it is fifty-eight years. This has been due, not so much to the extension of old age, as to the saving of young life. During the 13th century, one-half of all babies died before one year of age. Today, one out of twenty-five dies. This has been a great factor, along with the saving of older children, in increasing the average length of life, although many other factors have played an important part. I can, however, mention only a few of them in the time allotted.

Smallpox has been known to exist almost since the dawn of history. Its ravages wrought distress to all nations. It has wiped out families, reduced armies, decided wars, and left people marked and miserable for life. Its ravages continued without obstruction until innoculation was introduced about the year 1700. This was used with some success to immunize individuals and was also a stepping stone upon which Jenner, in 1798, gave us vaccination.

Vaccination has continued with many improvements in vaccine and technique since that time.

*Read before the Pinellas County Medical Society, August 21, 1936.

This has controlled the disease in a remarkable way. In Denmark, 15,000 people died of smallpox in 1779 and 12,000 in 1784. Vaccination became compulsory in 1801, and in 1822, eleven died of this disease. No other means are needed to stamp it out except laws to require everybody to be vaccinated. Some of our states and foreign nations have laws requiring vaccination before the child can enter school. In these states and nations, marked reductions of deaths in smallpox have been noted. Law is difficult to get because of certain organizations which, because of ignorance and prejudice, object.

As an example of the value of vaccination for smallpox, I wish to point to the year 1929 in Illinois. This state has no vaccination laws and 4,251 deaths from this filthy disease were reported during this year. This was 3,000 more cases than the aggregate in France, Germany, Italy, Belgium, Netherlands, Poland, Japan, Philippine Islands, Cuba, Switzerland, and the Panama Canal Zone. These nations have compulsory vaccination laws, and have an aggregate population of at least forty times that of Illinois. Again, with three times the population, New York and Pennsylvania had together less than 350 cases of smallpox during 1929 against 4,251 for Illinois. Eleven states having compulsory vaccination laws had together, less than 2,000 cases, or less than one-half the cases in Illinois. With these facts in mind, one can readily see what vaccination has done for the health and comfort of people of the world in preventing the disease. It is known that forty per cent of all patients with smallpox died before the use of vaccination.

Typhoid fever was first recognized as a disease 200 years ago. Some authors maintain that it existed much earlier than this, but it was badly confused with typhus fever until it was definitely differentiated from it by Gearhart in 1837. Since then, it has been recognized as a distinct entity, but it was not until 1880 that the typhoid germ was discovered by Eberth. This laid the foundation for a better understanding of the disease. Typhoid was once a disease of great importance, involving vast multitudes in various epidemics. Today it is one of the conquered diseases. Ways are known to control it completely. During the Civil War, 1,000 out of every 100,000 enlisted men died from this disease and this was not considered unusual at that time. During the Spanish-American War, 100 out of every 100,000 enlisted men died from the disease. This created a national scandal. During the World War, 5 out of every 100,000 enlisted men died from the disease.

The important factors in eliminating this disease as a destructive force, were the discovery of the germ and its natural habits, sanitation, and vaccination.

Diphtheria has been known under various names, throughout the ages. Children up to ten years of age suffer the most. Some fifty to seventy-five per cent of those contracting the disease died. The toll of life among children was terrific.

Dr. Sampson, a friend of mine who practiced in a rural section of Canada, told me of two families living in the country, who had contracted the disease. He administered the usual things in those days; when he returned a few days later, every member of both families was dead.

The ravages of the disease began early in the history of the world and continued until modern science discovered the germ about 1882. An antitoxin was made that reduced the mortality rate in a few years to 12%. This was followed by the Schick test, toxin, and antitoxin, until now no one need have the disease or, if contracted, die of it.

Typhoid, smallpox, and diphtheria are probably the best samples in the progress made in controlling and eliminating infectious diseases. There are, however, other infectious diseases that have received marked attention with reduction in their ravages.

Tuberculosis has been reduced sixty-six and two-thirds per cent since 1900; great advances have been made in the diagnosis and treatment of syphilis; malaria and hookworm diseases can be completely controlled; yellow fever has been practically eliminated. Typhus fever probably has caused more deaths in armies than any other disease. Since it is a disease known to be spread by rats, fleas, and lice, it is only a matter of sanitation and cleanliness to bring the disease under control, even in armies. It is reported that more than a million men died of this disease during the World War; during the ages, it has been said to have been the means of deciding more wars than any other factor.

The control of these infectious diseases can never be complete until the people are educated along this line. Governmental agencies must

give us laws to compel sanitation and vaccination. It is very easy to get laws and vaccines to stamp out contagious diseases in animals, but when it affects people, cults and conscientious objectors spring up who have great influence with lawmakers. When lawmakers and governmental agencies consider human life as important as they do that of live stock, then we can completely control many of the infectious diseases and probably remember them only in history.

In the metabolic diseases, diabetes has been greatly lessened in its ravages by diet and insulin. The young who have been so susceptible to this disease have new hopes which have proved to be life-savers to them. The lives of older people, although not greatly lengthened, have been made more comfortable.

Pernicious anemia, that only a few years ago was considered fatal in a short time, has now a liver extract, a treatment giving hope to those suffering from the disease, a chance to live on in comfort. With the exception of smallpox, the infectious diseases continued to make inroads, with no progress made until about sixty years ago. The men preceding this era, laid the foundation and deserve much credit for the discovery of germs. This was one of the greatest discoveries in science, before which little progress could have been made in combating infectious diseases. Surgery was at a standstill. Surgeons were afraid to operate upon the abdomen because of infection. This branch of medicine has been developed since the discovery of germs; the advance has been rapid, with new developments every day adding to the many already made.

As I look back at the accomplishments made by our profession, thinking first of the gradual development up to the present time, then the sudden advance during the life span of the older men of the profession, with the present foundation, the future looks bright for a greater advancement during the next three-score years. We belong to a great profession that marches on!

Notify the Vinoy Park Hotel, St. Petersburg, at once if you wish to have a room at the headquarters hotel.

THE APPLICATION OF PSYCHIATRY TO SCHOOL AND BUSINESS*

WHITMAN CARLISLE McCONNELL, M.D.,
St. Petersburg.

Psychiatry is too often considered to be a theoretical, impractical pastime. As its physiologic associate, psychology, has been a dynamic factor in business, so psychiatry should be made a partner when business is ill. From kindergarten to retirement, business is just as strong as the directing force behind it.

In the school, psychiatry should sit on the school board and with the faculty to direct the child who cannot maintain his class average. The school nurse should not only be a qualified graduate nurse but also a woman trained in psychology and psychiatry. During her tour of duty, she may observe the children and direct teachers in the art of observing faults analytically rather than dogmatically—as just bad youngsters.

A child may suffer from an incorrectable quantitative mental defect and money spent for his education will be wasted unless he is catalogued and directed early into a channel in which he may become a useful, self-supporting craftsman. To steep his impervious mind in academic knowledge is as ineffectual as the proverbial broth made from stone. The deduction of an incurable defect must be made only after complete examination of the child, correction of all possible body defects and environmental handicaps, and a sufficient period of observation. The various mental tests are not nearly so important as frequent contacts with the child.

The defective child must be protected against the ridicule of his playmates and be placed in that little niche of life to which his mind and talents are adaptable. Our failure to realize his mental handicap before he does may lead to major aberrations in defense or defiance when he does recognize his maladjustment. Benevolent school may become a monster of fear to him and develop in him a contempt for all society. He may become, not only a disagreeable individual, a failure and a vagrant, but a public menace because of a long smouldering hate. "The human is essentially primitive and is ruled by impulses and instincts; that which opposes the satisfaction of instinct is looked upon as hostile and that which is hostile is hated. Thus, the primitive attitude of man is hatred; love is

*Read before the Pinellas County Medical Society, St. Petersburg, March 1, 1935.

a cultural product."[1] (I have spoken and will speak of the individual in the masculine, but girls are equally involved in mental conflict.)

Psychiatry should be represented in the Employment Office of large business. The unappraised individual, upon quitting school, may seek and obtain employment for which he is emotionally unfit. The demand of attention to business routine becomes a problem of despair to him. He develops an exaggerated ego to mask his handicap. This makes him disliked by others and, in self-defense, he crawls into his shell, as it were. Here he develops a "split personality" because of conflict between reality and idealism. His sadistic traits delight in inflicting shame and blame upon unsuspecting people for whom he has an unreasonable and unfounded dislike. To gain his end, he may assume "good fellowship" towards them whom he aims to hurt. He will betray confidences for his own gratification and to their embarrassment. He will steal or destroy valuables entrusted to the care of others and sit back with satanic delight upon their conviction and imprisonment. Or the youthful adult may find his dreams of power and fortune shattered by the time clock bell and decide that he has met an unsurmountable obstacle. In defense of his pride, he simulates disease. His employer hesitates to discharge him because of sympathy for him and his little family. He may report for duty either periodically or persistently as a martyr of loyalty. He annoys and depresses his co-workers by belching, sighing and in other ways keeping them informed of his wretchedness. He detracts from their efficiency in addition to being of no use himself. Or he may accept masochism or fetishism as an expression of his neurosis. Psychiatry may identify the intolerable situation and direct him into vocations for which he is suited and for which he should have been trained in childhood. Such action may avert the inevitable complete "blow up" when the employer can no longer afford the incumbrance. This is followed by years of suffering by the patient and his innocent dependents at the expense of society.

Psychiatry should advise the man who is successfully working for others and decides to enter business for himself. The unstable individual may be the high pressure, star salesman about whom his traveling friends marvel. But he vacillates and a decision is never final. He must take frequent periods "off" because of "overwork." As an employer, he is a complete failure. Bankruptcy, nervous breakdowns and often suicide terminate the picture, where he might have continued in high esteem for years as an employee.

Psychiatry should listen at directors' meetings. With the advance to the administrative age, the old Treponema, long since forgotten, may have nestled in the capillary walls and the trusted executive may develop delusions of grandeur. Because of his past acumen, his directors hesitate to question his judgment. He feels his insight is superior to theirs and fails to present important matters to the Board for decision. At about the time he declares that he is Napoleon, the shadow of the sheriff becomes plainly visible to his colleagues. Stockholders, many of whom can ill afford loss, suffer because paresis was unidentified. Psychiatry could have noticed the change from conservatism to expansion and would have sounded the warning signal before collapse was inevitable.

As business has learned that it is economy to guard machinery and attend to employes' physical health, it will see the wisdom of having psychiatry represented in its various departments as safeguards against mental hazards.

1. Karpman, Ben: Obsessive Paraphilias (Perversions). Arch. N. P., 32: 577-626 (Sept.) 1934.

ATTENTION !

If you are a delegate to the Florida Medical Association convention, be sure to secure your credentials card from the Secretary of your County Medical Society before leaving home.

The names of all delegates and alternates should be in the hands of the Secretary of the State Association now. Secretaries, delegates and alternates are urged to see that this information is sent to the Association, Box 1018, Jacksonville, at once.

St. Petersburg, The Convention City

When the Florida Medical Association meets in St. Petersburg in April its members will find "The Sunshine City" in its most delightful mood. Temperatures are perfect for the many outdoor amusements which the resort provides for its visitors, such as golf, tennis, horseback riding, fishing, bathing and yachting.

Famed as the ideal convention city, St. Petersburg not only offers visitors the maximum in comfort in the way of hotel accommodations, restaurants and assembly rooms but has facilities for a wider variety of games, hobbies and pastimes than can be found in any other American city.

Social opportunities are as diverse as the field of sports. In the past year a quarter million dollars has been spent by hotels, clubs and individuals in equipping ultra-modern cocktail lounges and salons and for those who like gaiety after dark there are smart night clubs in the city and on the gulf keys.

There are five 18-hole golf courses within the city limits and a dozen others within easy driving distance. Fishing facilities are unsurpassed anywhere, the angler having the choice of dropping his line from one of the many fishing balconies on Recreation Pier, from a dozen bridges over tidal passes, inlets and bayous, from small boats and cruisers in Tampa and Boca Ceiga bays or he may obtain an expert guide and fish for "big game" out in the deep waters of the Gulf of Mexico.

Waters adjacent to St. Petersburg are inhab-



VINOY PARK HOTEL, CONVENTION HEADQUARTERS

You are requested to notify the Vinoy Park Hotel, St. Petersburg, immediately, if you desire a room during the convention. The rate is $6.00 a day, American plan, and includes the price of the Association Dinner ticket ($3.00), Tuesday evening.

There will be luncheons for the ladies and for various groups such as the Southeastern Surgical Congress, the Dermatological Society, Fraternities, and others, which will be listed in the program or announced. All luncheons served in the hotel, taking the place of one of your three meals, will be included in your hotel rate and not charged for extra by the headquarters hotel.

The management of the Vinoy Park Hotel is cooperating one hundred per cent. It will aid the hotel in giving you better service if you will take the time right now to drop a card or send a wire, telling that you will want a room during the convention. This courtesy on your part, if promptly executed, will be very much appreciated.

ited by more than 600 varieties of food and game fish, including the mighty silver-scaled tarpon which will be running when the medical convention is in session, the kingfish, amber jack, grouper, robalo, mackerel, red snapper and many others famed for their fighting prowess or palatableness.

For those who like sailing and cruising there are miles of coastal and inland waters traversing veritable fairyland of tropical verdure. Jutting a mile into Tampa Bay is the famous "Million Dollar Recreation Pier" with its spacious casino, convention hall, picnic rooms and radio studios. At the foot of the pier is the Spa Municipal Beach, only a few blocks from the heart of the hotel and shopping district, with its facilities for swimming and sun bathing, its salt water pool, recreation park, and the municipal sun bathing temple where thousands expose their bodies to the rays of Old Sol.

Other diversions include shuffleboard, lawn bowling, tennis, horseshoe pitching, archery, roque, chess and checkers, handball, trapshooting, skeet, and power boat racing.

St. Petersburg is so distinctive in character and natural beauty that thousands from every northern state and Canada return year after year to rest and play in its perpetual sunshine. Situated on the southern tip of beautiful Pinellas peninsula, the Sunshine City is almost surrounded by the mild waters of Tampa Bay and the Gulf of Mexico. Off its 33 miles of shore are palm-fringed isles and keys, with white, sandy, shell-strewn beaches, the home of gulls,



Recreation Pier



Golf

pelicans, herons, cormorants, pink ibis and egrets. So dependable is the sunshine that "The Evening Independent" for more than 25 years has given away its home edition every day the sun has not broken through the clouds before 3 p. m., press time. Only 123 free papers have been issued in 26 years, less than five a year.

Members of the Florida Medical Association will find St. Petersburg at its best in April, at the time they gather in session here. They will see the city's rich profusion of tropical growth flowering in all its beauty. They will find the city relaxing from one of the biggest seasons in its history, but alert as ever to look out for the comfort, convenience and happiness of its convention guests. Many of the convention visitors will have noted many pleasing changes about the far-famed Sunshine City, changes that add to the beauty and charm of St. Petersburg in its landscaping and in its newest architecture applicable to this climate.

For the first time visitor, among the many different places of interest include the one-mile-long Recreation Pier jutting out into Tampa Bay and on which is located the first Municipal Solarium in America. Not far away is the only private school in the country where classes are held daily in a schoolroom that has a banyan tree for a roof. In the heart of the city is the first open-air post office built in the country.

St. Petersburg is the only resort in America that provides tens of thousands of green benches for its visitors. It is on one end of the nation's longest automobile toll bridge. It has the only



Recreation Pier

open-air public school in the United States where pupils and teachers attend classes in bathing suits. Swimming is taught as a part of the school curriculum. It has the Southland's longest white way system of illumination.

There are ample cars for hire and taxi-cabs on 24-hour service. Every type vessel is available for fishing and boating excursions. At the Chamber of Commerce Tourist Registration Bureau are a corps of young women information clerks who have answers to all questions—and a lot more answers.

Clearwater, Florida

Midway down the Gulf Coast of Florida, twenty-two miles north of St. Petersburg, lies the charming little city of Clearwater with a permanent population of 9,085. During the winter season this is more than doubled.

Wonderful facilities are offered for golf, boating, fishing, swimming, shuffleboard, lawn bowling, tennis and many other forms of entertainment. Three 18-hole golf courses are available within a three-mile radius. Fishing is one of the major sports and snapper, grouper, bluefish and other species are found the year round. The best season for trout, kingfish and redfish is from January 15 to April 15.

Clearwater Beach, one of the finest in the state, is on the Gulf and connected with the mainland by the free Memorial Causeway. This stretch of white sandy beach is dotted with pavilions, piers, playgrounds and everything to make surf-bathing enjoyable.

The Japanese Gardens, a replica of the gardens of Japan, combined with the natural tropical beauty of their setting, is one of the show places of Clearwater. The Seville Peacock Farm has the largest collection of peafowls in America.

An excellent system of paved highways connect Clearwater with all points. Federal Highways 19 and 92 and State Highways 15 and 17 follow the principal streets of the city. The rich back country of Pinellas County produces one-seventh of the state's output of citrus fruit and Clearwater is the marketing and canning center for this crop.



Municipal Sun Bathing Temple



On One of St. Petersburg's Five Tropical Golf Courses

Points of Interest In Tarpon Springs.

River Trip: Trips up the Anclote River, from the Sponge Exchange docks, reveal at each turn an endless array of semi-tropical beauty. It was here at Camp Comfort that the late George Inness, Jr., did much of his painting.

Inness Paintings: At the Church of the Good Shepherd, Universalist, corner of Read and Grand Boulevard. Open each afternoon from 3:00 to 5:00 o'clock, including Sunday; also open during service Sunday morning.

Sponge Exchange: The sponge industry is always interesting, and visitors are always wel-



LANDING A TARPON

come. Time most certain to find all boats in is from January 1st to the middle of the month, sometimes later. However, they come and go nearly every day and there are always some of the boats in. Sponge sales are usually held on Tuesdays and Fridays, when sponges are available.

With water boundary in three directions by gulf, river and lake in addition to the numerous bayous within its city limits, Tarpon Springs is one of the prettiest little towns on the West Coast.

CONVENTION HEADQUARTERS

The Vinoy Park Hotel, convention headquarters of the Florida Medical Association, April 5, 6, and 7, is situated in the best residential section of St. Petersburg, overlooking a private yacht basin and beautiful Tampa Bay. The hotel, located between Fifth and Sixth Avenues north, spans a full city block. It is the largest fireproof hotel on the west coast of Florida, consisting of 375 rooms each with private bath. Accommodations are available for more than 700 guests.



SAILING IN THE BAY

The main dining room, operated on the American Plan, has a seating capacity of 700. This room with its brilliant Pompeian decorations, rich hangings and floor coverings, is considered one of the most attractive hotel dining rooms in Florida. The food is prepared and served by a staff of trained white servitors, and there is a wide choice.

The ball room with rose hangings and soft harmonious lighting effects is one of the most beautiful in the country. It is well ventilated and always pleasantly cool. This room is also used for convention meetings; 1,000 people may be seated comfortably here.

The modern Spanish decorations in the Palm Room provide an attractive background for all types of exhibits. There are over 4,000 square feet of exhibition space in this room, which is situated directly off the main foyer approaching the ball room or meeting room.



WALK ALONG YACHT BASIN FROM VINOY PARK HOTEL

The bedrooms at the Vinoy Park are very attractively furnished. They average 15 by 14 feet in size. Every room has modern bath, seven-foot closet space and at least two windows. Each room is equipped with twin beds. The outstanding features of the sleeping rooms are their modern equipment, excellent bedding, large closets and adequate window space for sunshine and ventilation.

Two large terraces or porches overlooking Tampa Bay and leading from the mezzanine and main floor are equipped with Cape Cod hammocks and comfortable chairs. In the evening these terraces, transformed into moon gardens, are a delightful place to sit and enjoy St. Petersburg and Tampa Bay by moonlight.

PROGRAM

of the

SIXTY-FOURTH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD AT ST. PETERSBURG, FLORIDA

APRIL 5, 6 and 7, 1937

INFORMATION

The information desk will be located in the Palm Room of the headquarters hotel, the Vinoy Park Hotel, with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests and ladies are required to register. Tickets for the dinner, Tuesday evening, April 6, may be obtained at the registration desk. Cost of dinner included in hotel rate for those registered at the Vinoy Park.

HOTELS

Vinoy Park Hotel—Convention Headquarters.

(American Plan)

Vinoy Park	$6.00
Soreno	$6.00

No charge to guests of the Vinoy Park Hotel for Tuesday night Dinner tickets.

(European Plan)

	Single	Double
Ponce de Leon	$4.00	$5.00
Suwannee	3.00	5.00
Pheil	3.00	5.00
Princess Martha	3.00	5.00
Poinsetta	2.50	4.00

TECHNICAL EXHIBITS

Technical exhibits will be located in the Palm Room of the Vinoy Park Hotel.

The technical exhibits have a real scientific value and physicians who wish to keep abreast of the times and know the latest in drugs and medical appliances should spend some time with these exhibits. It will be surprising the amount of useful information that can be procured at these exhibits. Many have nothing for sale, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the St. Petersburg meeting:

A. S. Aloe Co.
American Optical Co.
Bard-Parker Co., Inc.
Bilhuber-Knoll Corp.
DuPont Film Mfg. Co.
H. G. Fischer & Co.
C. B. Fleet Co., Inc.
General Electric X-ray Corp.
Horlick's Malted Milk Corp.
Keleket X-ray Co. of Florida.
Kellogg Co.
McIntosh Electrical Corp.
Mead Johnson & Co.
Miami Surgical Co.
M. & R. Dietetic Laboratories, Inc.
C. V. Mosby Co.
Petrolager Laboratories, Inc.
Philip Morris & Co., Ltd.
Southeastern Optical Co., Inc.
E. R. Squibb & Sons.
Surgical Supply Co.
Westinghouse Electric Supply Co.

SCIENTIFIC EXHIBITS

American Medical Association.
Florida State Hospital.
Medical Post-Graduate Course.
State Tuberculosis Sanatorium.
Woman's Auxiliary.

GOLF

RULES GOVERNING MEN'S GOLF TOURNAMENT

1. Time: Monday and Tuesday, April 5 and 6.
2. Place: Lakewood Country Club.
3. Rules U. S. Golf Association. See card for local rules.
4. Handicaps: Three-fourths official handicap with a maximum of 27 strokes. The entrant must state his handicap to the starter before beginning the tournament round. In case the player does not possess a handicap one will be given to him by the starter.
5. Although the tournament round may be played on either day noted above, the player must specify his intention to the starter before beginning the tournament round.
6. Score Card: Dated, signed, attested and turned in to the starter at the end of the tournament round.
7. Prizes awarded for 18 holes play as follows:
 First Prize: Orlando Cup (low net score).
 Second Prize: Runner-up (2nd low net score) donated by Pinellas County Medical Society.
 Third Prize: (Low gross medal score), donated by Mr. Henry Parramore, President, Surgical Supply Company.
 Fourth Prize: (2nd low gross medal score), donated by the American Optical Co.
 Other prizes to be donated by the Southeastern Optical Co. and the St. Petersburg Chamber of Commerce.

FISHING TRIPS

Fishing parties may be arranged during the annual meeting. Please write in to arrange date and number in your party. The cost will be about $5.00 per person, which includes all fishing tackle needed. Address reservations to C. B. Wright, M.D., Chairman, Anglers' Committee, 214 Equitable Building, St. Petersburg. During the convention, information concerning fishing trips may be secured through Doctor Wright. If you are unable to locate Doctor Wright, you are requested to leave a message at the registration desk.

SWIMMING

Swimming in the Gulf. Bring your swimming suits.

PUBLIC MEETING, WILLIAMS PARK

Monday, April 5, 7:30 P. M.

A Public Meeting will be held in Williams Park at which Doctor Morris Fishbein will speak on "Food Fads and Follies." Music will precede the lecture.

SMOKER

Monday, April 5, 9:30 P. M.

St. Petersburg Yacht Club. (*Stag*).
Entertainment—Refreshments.

ASSOCIATION DINNER

Tuesday, April 6

7:00 P.M. Cocktails.
7:30 P.M. Dinner.

The Association Dinner will be held at the Vinoy Park Hotel. Tickets ($3.00) may be obtained at the registration desk by persons not residing at the headquarters hotel. Cost of dinner is included in hotel rate for those registered at the Vinoy Park Hotel. Following the dinner, there will be dancing.

OFFICERS OF PINELLAS COUNTY MEDICAL SOCIETY

NORVAL M. MARR, *President*
EARL C. MACCORDY, *First Vice-President*
LESTER W. HORNE, *Second Vice-President*
WHITMAN C. MCCONNELL, *Secretary-Treas.*

LOCAL COMMITTEES

Cabinet Committee
Norval M. Marr, *Chairman*

C. O. Anderson	Roscoe H. Knowlton
Annette M. Bieker	Prescott LeBreton
William M. Davis	G. M. Lochner
Linwood M. Gable	Whitman C. McConnell
N. Wilson Gable	Earl C. MacCordy
John A. Herring	A. L. Mills

Committee on Registration
Earl C. MacCordy, *Chairman*

R. H. Center	Richard B. Leith
T. H. Green	W. E. Quicksall
Frank S. Jennings	Carl A. Williams

Committee on Exhibits
Prescott LeBreton, *Chairman*

J. M. Anderson	H. D. Solomon
Francis H. Langley	M. H. Stuart
Lawrence Simcox	Benjamin L. White

Committee on Association Dinner
Annette M. Bieker, *Chairman*

A. S. Anderson	Raymond K. O'Brien
Frank E. Kauffman	Council C. Rudolph
M. A. Nickle	

Committee on Smoker
Linwood M. Gable, *Chairman*

Neil E. Funk	W. H. Groves
N. W. Gable, Jr.	Lester W. Horne
T. R. Griffin	R. W. S. Owen

Committee on Publicity
William M. Davis, *Chairman*

William D. Anderson	J. Braden Quicksall
A. R. Frederick	Grace Whitford
Ralph D. Murphy	Alvin J. Wood

Committee on Projecting Lantern
G. M. Lochner, *Chairman*

P. H. Guinand	B. T. Prather
Eugene A. Heibner	Howard M. Rogers
Thomas E. Morgan	

Anglers' Committee
Claude B. Wright, *Chairman*

J. H. Cooper	L. Lambdin
John Hagood	Gideon Timberlake
W. W. Harden	

Committee on Golf
Roscoe H. Knowlton, *Chairman*

Lucien B. Dickerson	LeRoy A. Wylie
C. E. Hebard	

Greeters' Committee
N. W. Gable, Sr., *Chairman*

Andrew P. Albaugh	M. W. Moeller
M. Eldridge Black	Louis B. Mount
John T. Bowen	G. E. Osgood
Reid E. Dicks	Harrison G. Palmer
C. K. Farber	J. D. Peabody
Emil Lustig	A. P. Roope
John A. Mease, Jr.	Jesse A. Strickland
Edmond J. Melville	Leon Thurston

Committee on Park Program and Radio Broadcast
Alvin L. Mills, *Chairman*

S. A. Dawson	Robbins Nettles
Frederick F. Kumm	W. G. Post, Jr.

Ladies' Advisory Committee
John A. Herring, *Chairman*

T. B. Echard	George E. Miller
John A. Hardenbergh	Franklin W. Roush

Finance Committee
Whitman C. McConnell, *Chairman*

Arthur J. Bieker, Jr.	Orville N. Nelson
W. H. Bradford	H. E. Winchester

Committee on Alumni and Fraternity Luncheons
C. O. Anderson, *Chairman*

William P. Farber	J. Sudler Hood
C. S. Franckle	Hugh W. Wade

FIRST GENERAL SESSION

Monday, April 5, 1:30 P. M.

BALL ROOM

Call to Order, President O. O. Feaster.
Invocation, Dr. J. A. McClure, Pastor, First Presbyterian Church, St. Petersburg.
Address of Welcome, Hon. J. A. Smith, Mayor, St. Petersburg.
Address of Welcome, Norval M. Marr, M.D., President, Pinellas County Medical Society.
Introduction, Delegates from other State Societies.
New Business.
Announcements.

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Leigh F. Robinson, Ft. Lauderdale; L. M. Anderson, Lake City; John R. Chappell, Orlando; R. H. Knowlton, St. Petersburg; Thomas M. Palmer, Jacksonville; C. C. Webb, Pensacola.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

The Duval County Medical Society has offered its projecting lantern and daylight screen and also its moving picture projector for use during the convention. Mr. Henry Parramore and his staff of the Surgical Supply Company will operate these machines and look after the showing of slides and films for essayists. Essayists wishing to illustrate their papers with lantern slides or moving picture films should communicate with Dr. George M. Lochner, Power and Light Building, St. Petersburg, chairman of the committee in charge.

FIRST SCIENTIFIC ASSEMBLY

Monday, April 5, 2:30 P. M.

BALL ROOM

1. "Some Observations on Blood Pressure", J. G. Gainey, Blountstown.

 Personal experience and observation on about 500 private cases of blood pressure recordings in home, office, and hospital; including different ages, color and sex. Correlation of etiological factors, subjective findings and symptoms, and objective findings to both, text book findings and present day conceptions of blood pressure variations.

 Discussion: Spencer A. Folsom, Orlando; R. H. Stovall, Ft. Lauderdale.

2. "Trichinosis", T. F. Hahn, DeLand.

 Etiology, parasitology, diagnosis, prognosis, and treatment of this bizarre condition. Report of case which showed localization in the vestibular apparatus, the only such case the author has found reported in literature.

 Discussion: Herbert L. Bryans, Pensacola; Meredith Mallory, Orlando.

3. "The Diagnosis of Coronary Heart Disease", William C. Blake, Tampa.

 Increase in coronary disease during recent years. Pathology. Symptomatology: angina pectoris; coronary thrombosis; common errors in evaluating symptoms. Chronic myocarditis. Electrocardiographic studies and their value in diagnosis and prognosis.

 Discussion: E. Sterling Nichol, Miami; Louie M. Limbaugh, Jacksonville.

4. "Heart Block", T. Z. Cason, Jacksonville.

 Various forms of heart block, including blocks in the auricles and bundle of His; left and right ventricular bundle branch blocks. Presentation of grapbs showing normal electrical beart conduction as shown by the electrocardiogram; also two abnormal tracings. Animated drawing showing a moving photograph of the normal heart action along witb its electrical nerve conduction.

 Discussion: Arthur L. Walters, Miami Beach; Edwin C. Swift, Jacksonville.

5. "Treatment of Tetanus", Joseph S. Stewart, Miami.

 Tbe germ, how it grows. The toxin, how it gains entrance to the central nervous system. Tbe toxin and the brain. Prophylactic treatment: excision of punctured wounds; debridement; tetanus antitoxin; theoretical harm in cauterization. Symptoms and relation of convulsions to mortality. Treatment: excision of site of injury; sedation; fluid balance and nourisbment; nursing care; serum given intravenously in saline and none intraspinally. Statistics and case histories. Mortality.

 Discussion: S. Ward Fleming, West Palm Beach; Reddin Britt, St. Augustine.

6. "Syphilis", Henry E. Palmer, Tallahassee.

 Prevalence. Cost in money and lives. An appeal for action along preventive and curative lines.

 Discussion: E. B. Hardee, Vero Beach; Thomas M. Rivers, Kissimmee.

FIRST MEETING OF HOUSE OF DELEGATES

Monday, April 5, 7:00 P. M.

EAST END OF BALL ROOM

President Feaster in the Chair.

Roll Call and seating of delegates.

Adoption of minutes as published in May, 1936, Journal.

Election of one delegate and one alternate to A. M. A. meeting for two-year terms.

(A. M. A. By-Law, Chapter 1, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.")

Consideration of proposed amendments to Constitution.

Reading of Resolutions.

Reports of Committees:

- Legislation and Public Policy, Julius C. Davis.
- Medical Education and Hospitals, J. Knox Simpson.
- Publication, Walter C. Jones, Jr.
- Public Relations, J. Ralston Wells.
- Necrology, Calvin D. Christ.
- Medical Post-Graduate Course, T. Z. Cason.
- Cancer Control, F. Clifton Moor.
- Medical Economics, J. C. Vinson.
- Venereal Disease Control, E. T. Sellers.
- Inter-Relationship, William M. Rowlett.
- Tuberculosis and Public Health, M. Jay Flipse.
- State Controlled Medical Institutions, H. Mason Smith.
- Maternal Welfare and Child Health, Homer L. Pearson.
- Advisory to Woman's Auxiliary, Gordon H. Ira.
- Delegates to A. M. A., Herbert L. Bryans and Meredith Mallory.
- Other Committees.

Report of Council Chairman, W. McL. Shaw.

New Business.

Announcements.

Adjournment.

PUBLIC MEETING, WILLIAMS PARK

Monday, April 5, 7:30 P. M.

Music.

Introduction of Dr. Morris Fishbein by President O. O. Feaster.

Address, "Food Fads and Follies", Morris Fishbein, Editor of Journal of American Medical Association and Hygeia.

SECOND SCIENTIFIC ASSEMBLY

Tuesday, April 6, 9:00 A. M.

BALL ROOM

7. "Acute Appendicitis in Children", Douglas D. Martin, Tampa.

 Relation of abdominal pain and tenderness to the pathology of the appendix. Inconsistency of pain over McBurney's point to disease of appendix. Cardinal signs and symptoms found over a period of years in belping to establish a diagnosis of appendicitis in children. Differentiation from other puzzling conditions that occur in children. Case histories.

 Discussion: Gilbert S. Osincup, Orlando; Warren Quillian, Coral Gables.

8. "Cooperation of State Board of Health and Medical Profession", W. A. McPhaul, Jacksonville.

 Discussion: N. A. Baltzell, Marianna; George N. MacDonell, Miami.

SECOND GENERAL SESSION

Tuesday, April 6, 10:00 A. M.

BALL ROOM

Call to Order, O. O. Feaster, President.

Reports of Officers and Committees:

Secretary-Treasurer-Editor, Shaler Richardson, and Business Manager, Stewart Thompson.

Executive Committee, Gilbert S. Osincup.

Presidential Address, O. O. Feaster, St. Petersburg.

Address, J. H. J. Upham, President-elect, A. M. A., Columbus, Ohio.

Address by Guest of Honor, Morris Fishbein, Editor Journal of A. M. A., Chicago.

THIRD SCIENTIFIC ASSEMBLY

Tuesday, April 6, 2:00 P. M.

BALL ROOM

9. "Use and Abuse of the X-ray in the Treatment of Skin Diseases", Wiley M. Sams, Miami.

Introduction of roentgen therapy into dermatology. Nature and theory of its action. Common skin diseases in which x-ray therapy is the most useful form of treatment. Roentgen therapy in acute conditions. Misuse of radiation therapy in the management of chronic dermatoses.

Discussion: J. L. Kirby-Smith, Jacksonville; Frazier J. Payton, Miami Beach.

10. "Carcinoma of the Body of the Uterus", Cayetano Panettiere, Miami Beach.

Incidence: age, menopause, childbearing. Symptoms. Differential diagnosis. Treatment: surgery, irradiation. Results, five-year status.

Discussion: Henry C. Dozier, Ocala; W. C. Payne, Pensacola.

11. "Traumatic Surgery", Lloyd J. Netto, West Palm Beach.

Ten years' experience with injuries of minor nature in office practice. Common errors in diagnosis and treatment and some possible bad consequences. Relation with compensation boards. Satisfactory routine procedures. Case records.

Discussion: Walter C. Jones, Jr., Miami; Eugene L. Jewett, Orlando.

12. "Gonorrheal Arthritis", Arthur H. Weiland and Charles R. Burbacher, Coral Gables.

Historical aspect of disease; typical clinical course; joints involved; various types of therapy used in past. A new treatment which often aborts the joint manifestations promptly.

Discussion: Prescott LeBreton, St. Petersburg; J. C. Vinson, Tampa.

13. "Reaction Following Application of X-ray Therapy" (colored motion pictures, lantern slides), H. Bernard McEuen, Jacksonville.

Film will show cases before treatment, during treatment and after treatment. Reaction following modern technique in application of x-ray therapy, especially the so-called deep x-ray therapy. Suggestions to the general practitioner regarding after care. Case illustrations. Skin reactions following x-radiation for treatment of cancer of uterine cervic and brief description of combined x-radiation and radium technic with one slide showing five-year results in Memorial Hospital as contrasted with surgery in Johns Hopkins and Mayo Clinic.

Discussion: Elliott M. Hendricks, Ft. Lauderdale; Walter A. Weed, Orlando.

14. "A Simplified Method of Treating Fractures of the Shaft of the Humerus" (lantern slides), Charles B. Mabry, Jacksonville.

Causes and types of fractures of the humerus and physiology of motion of humerus. Former methods of treatment evaluated and discussed. A comparatively new method presented which has as its basic principle the Boehler plaster splint. Case reports, showing short convalescence with no case of dysfunction of elbow or shoulder joints, or non-union. Cases where callus has bridged one-half inch of distraction.

Discussion. I. M. Hay, Melbourne; Leldon W. Martin, Sebring.

SECOND MEETING OF HOUSE OF DELEGATES

Tuesday, April 6, 5:00 P. M.

EAST END OF BALL ROOM

Unfinished Business.

FOURTH SCIENTIFIC ASSEMBLY

Wednesday, April 7, 9:00 A. M.

BALL ROOM

15. "Deafness From Drugs", H. Marshall Taylor, Jacksonville.

It has long been recognized that the eighth or auditory nerve is more often affected than any other of the nerves of special sense by the action of drugs circulating in the blood. This selective action which certain drugs have for the auditory apparatus and drug idiosyncrasy, which is peculiar to many persons, should always be borne in mind by both the otologist and the general practitioner of medicine. Degenerative changes in the delicate mechanism of the auditory apparatus due to alcohol, arsenic, carbondisulphide, carbonmonoxide, oil of chenopodium, lead, mercury, opium, phosphorus, quinine, salicylates and tobacco have been observed frequently and reported in the literature.

Discussion: G. E. Chandler, Miami; Roncie R. Duke, Tampa.

16. "Recent Advances in the Diagnosis and Treatment of Asthma", J. Ralph Vallotton, Daytona Beach.

Etiological classification of bronchial asthma: allergic—inhallation, ingestion, absorption from foci, therapeutic; non-allergic — pathological. Diagnosis: what diseases are to be considered; outline of differential diagnosis; methods for determining allergic manifestation. Treatment: medical, surgical, physiotherapy including ionization, vaccine, allergic.

Discussion: C. A. Clemmer, Daytona Beach.

17. "The Use of X-Radiation In Conditions Other Than Malignancy", Gerard Raap, Miami.

The efficacy of radiation in certain infections is a known fact and can be explained on a biochemical basis. Recent investigations show that a number of chronic conditions respond to radiation of the nerve roots and certain areas in the sympathetic and parasympathetic nerve chain with a fair percentage of favorable results. Certain pathologies dependent upon complicated glandular distrophies permit the use of radiation to alter a faulty glandular mechanism.

Judicious and conservative use of radiation must be considered an important adjunct in many instances and in others a therapeutic key note.

Discussion: J. N. Moore, Ocala; John W. Snyder, Miami.

18. "Surgery of the Ureter", (motion pictures, lantern slides), Robert B. McIver, Jacksonville.

The presentation is based on a study of the surgical lesions of the ureter that have been handled during a ten-year period at the Duval County Hospital and in the author's private practice. Congenital deformities, ureteropelvic obstructions, ureterovesical obstructions, accidental injuries to the ureter, operative and non-operative.

Discussion: Milton M. Coplan, Miami; Eugene S. Gilmer, Tampa.

19. "Hypoglycemic Shock Therapy in Schizophrenia with Report of Cases", H. Mason Smith, Tampa.
Discussion of Sakel's discovery of the value of hypoglycemic shock therapy and his first series of cases. Method of administering treatment. Results obtained in Sakel's Clinic and also in other European Clinics. Personal experiences, report of cases. Practical application of treatment in general hospitals.
Discussion: William H. Spiers, Orlando;
Ralph N. Greene, Coral Gables.

20. Travelogue: Moving pictures taken on Convention Cruise to and in Cuba. Herbert L. Bryans, Pensacola.

THIRD GENERAL SESSION

Wednesday, April 7, 12:00 Noon

BALL ROOM

President Feaster in the Chair.

Unfinished Business.

New Business.

Election of President-elect.

Election of First Vice-President.

Election of Second Vice-President.

Election of Third Vice-President.

Election of Secretary-Treasurer and Editor of Journal.

Dr. Edward Jelks escorted to the Chair as new President.

Presentation of Past-President's Button to Dr. O. O. Feaster, by Dr. L. M. Anderson, Lake City.

Adjournment.

PROGRAM FOR WOMEN

Local Committees

Mrs. Alvin L. Mills,
General Chairman of Arrangements.

Sub-Committee Chairmen

Mrs. O. O. Feaster	Mrs. Robbins Nettles
Mrs. L. M. Gable	Mrs. R. Wynn S. Owen
Mrs. W. W. Harden	Mrs. W. Glenn Post, Jr.
Mrs. John Hardenbergh	Mrs. J. B. Quicksall
Mrs. Francis Langley	Mrs. F. W. Roush
Mrs. N. M. Marr	Mrs. J. A. Strickland
Mrs. W. C. McConnell	Mrs. Hugh Wade

Monday, April 5th

11:00 A.M. Executive Board meeting and luncheon, Yacht Club.

1:45 P.M. Motorcade; visiting Japanese Gardens and tea house, Clearwater; tea served; also U. S. Veterans Administration Home, Bay Pines.

8:00 P.M. Greyhound racing—Kennel Club.
or
Sense and Nonsense Party, Lakewood Country Club.

11:00 to
12.00 P.M. All join in buffet supper, Lakewood Country Club.

In event of rain, afternoon program will be changed.

Tuesday, April 6th

9:30 A.M. General Auxiliary session followed immediately by post-convention board meeting, radio room, Vinoy Park Hotel.

12:30 P.M. Luncheon, mezzanine floor, Vinoy Park Hotel. (No charge for guests stopping at this hotel.)

3:00 P.M. Bridge Party, mezzanine floor.

6:30 P.M. Cocktail Party followed by Association dinner dance, Vinoy Park Hotel.

Women not making headquarters at Vinoy Park Hotel will please purchase luncheon tickets at hotel desk—$1.50. Tickets for Kennel Club provided by Registrar, courtesy of Kennel Club.

For Monday parties, time indicated on program means last car leaving; please be on porch fifteen minutes earlier so cars may be filled.

If willing to drive own car and accommodate others please notify registration desk.

Will you help us by registering promptly for various parties and being on time.

FLORIDA RAILWAY SURGEONS' ASSOCIATION

OFFICERS

President, T. M. McDuffee.....Manatee
President-elect, J. Ralston Wells.....Daytona Beach
Vice-President, V. A. Lockwood.....St. Augustine
Secretary-Treasurer, H. D. Clark.....Fort Pierce

COMMITTEES

Executive

J. W. Alsobrook, Chairman.....Plant City
H. C. Dozier Ocala
T. W. Hutson Miami

Scientific

A. R. Beyer, Chairman.....Tampa
Hugh West DeLand
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Necrology

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OPENING SESSION

Monday, April 5, 9:00 A. M.

BALL ROOM

Call to Order, J. Ralston Wells, President.
Minutes.
Reports of Committees.
President's Address.

SCIENTIFIC PROGRAM

Monday, April 5, 9:30 A. M.

BALL ROOM

A. R. Beyer and Committee in Charge.

Guest Speaker, "Cooperation of Railway Surgeons", W. J. Lancaster, Chief Surgeon, A.C.L. Ry.

1. "Old Compression Fractures of the Spine", John R. Boling, Tampa.
2. "Denervation of the Suprarenal Gland", C. D. Christ, Orlando.
3. "Physical Examinations in Railway Medicine", V. A. Lockwood, St. Augustine.
4. "Post-traumatic Osteoporosis", A. R. Beyer, Tampa.

Business Session.
Announcements.

PROGRAM OF THE SIXTH ANNUAL SPRING MEETING OF THE FLORIDA RADIOLOGICAL SOCIETY

Officers

President, Frazier J. Payton.....Miami Beach
Vice-President, Gerard Raap.....Miami
Secretary, Harold O. Brown.....Tampa

Vinoy Park Hotel
Room A, Mezzanine Floor.

Sunday, April 4, 1937

10:00 A.M. Round table discussion and exhibit of films.
2:00 P.M. Round table discussion and exhibit of films.

Monday, April 5, 1937
Room A, Mezzanine Floor.
10:00 A.M. Therapy discussion.
11:30 A.M. Election of Officers.

An exhibit will be maintained on x-ray diagnosis and therapy in charge of a member of the Society.

REGULAR QUARTERLY MEETING OF THE FLORIDA SOCIETY OF DERMATOLOGY AND SYPHILOLOGY

Officers

Chairman, J. L. Kirby-Smith.....Jacksonville
Secretary, Wiley M. Sams.....Miami

Monday, April 5, 10:00 A. M.
Vinoy Park Hotel
Room C, Mezzanine Floor.
Clinical Session.
Business Meeting.
Election of Officers.

SECOND ANNUAL MEETING OF THE FLORIDA PEDIATRIC SOCIETY

Officers

President, Luther W. Holloway.....Jacksonville
Vice-President, William E. Ross.....Jacksonville
Secretary-Treasurer, Warren Quillian....Coral Gables

Monday, April 5, 10:00 A. M.
Room B, Mezzanine Floor.
Guest Speaker, Earl R. Carlson, Chief of Department of Pediatrics, Neurological Institute, Medical Center, New York.

Round Table Discussion.
Business Meeting.
Election of Officers.

SOUTHEASTERN SURGICAL CONGRESS

Monday, April 5
Main Dining Room.
12:00 Noon Luncheon and Business Meeting.

Groups desiring tables for luncheon meetings, please see Mr. Miles, head waiter. There is ample room in the main dining room to locate group luncheon meetings so that one will not interfere with the other.

PAST PRESIDENTS

1885—Dr. Joseph Y. Porter, Key West.*
1886—
1887—
1888—
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1922—Dr. L. M. Anderson, Lake City.
1923—Dr. H. Marshall Taylor, Jacksonville.
1924—Dr. John C. Vinson, Tampa.
1925—Dr. John S. McEwan, Orlando.
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1928—Dr. F. J. Waas, Jacksonville.
1929—Dr. Henry C. Dozier, Ocala.
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1932—Dr. Gerry R. Holden, Jacksonville.
1933—Dr. William M. Rowlett, Tampa.
1934—Dr. Homer L. Pearson, Miami.
1935—Dr. Herbert L. Bryans, Pensacola.
1936—Dr. O. O. Feaster, St. Petersburg.

*Deceased.

Florida Medical Association, Inc.

JACKSONVILLE, FLORIDA
P. O. BOX 1018

SHALER RICHARDSON, M. D.
SECRETARY-TREASURER AND
EDITOR OF THE JOURNAL

STEWART G. THOMPSON, D. P. H.
BUSINESS MANAGER AND
DIRECTOR OF EXHIBITS

Regulations Regarding Exhibits

Arrangement of Exhibits.—The management will provide skeleton booths as indicated in diagrams, also signs of uniform style. No interference with the light or space of other exhibitors will be allowed.

Exhibitor is responsible for damage to property. No signs or other articles shall be posted, nailed, or otherwise attached to any of the pillars, walls, doors, etc., in such manner as to deface or destroy the same. No attachments shall be made to the floors by nails, screws, or any other devices that would in any way damage or mar them. All space leased subject to these restrictions.

Restrictions.—Exhibits should be confined, as far as practicable, to special articles, articles that are new, unique, or particularly attractive and scientific in character.

No proprietary drugs, chemicals, or therapeutic agents that do not comply with the rules of the Council on Pharmacy and Chemistry of the American Medical Association or which have not been accepted by the Council for inclusion in "New and Non-official Remedies", shall be exhibited, distributed, or in any way advertised in the hotel. (For copy of official rules of the Council on Pharmacy and Chemistry, write A. M. A.)

No medical journal or publication shall be exhibited that contains advertisements of drugs, chemicals, or any therapeutic agents which do not conform to the rules of the Council on Pharmacy and Chemistry of the American Medical Association.

Irregular Canvassing and Distribution of Advertising Matter.—Solicitation of business or conferences in the interests of business except by exhibiting firms, is prohibited. Canvassing by exhibitors outside of their booths is also forbidden. Circulars or advertising matter of any description shall not be distributed, except from the Exhibitor's booth.

Exhibits of Electrical and Radiographic Apparatus.—Machines and apparatus operated by electricity must he shown as "still" exhibits. Practical demonstrations of x-ray apparatus and accessories or of any noisy apparatus of any kind will not be permitted. No objection will be made to the utilization of electricity for illuminating purposes or for operating smaller diagnostic instruments and electro-therapeutic apparatus which are noiseless.

Subletting of Space.—No subletting of space will be permitted. Each firm represented in the Technical Exhibit must sign the regular form "Application for Space in the Technical Exhibit." Any person or firm subletting space as well as the one purchasing space, will be subject to eviction. No refund will be made for space reserved.

Uncontrollable Eventualities.—The Florida Medical Association, Inc., will take all reasonable precautions against damage or loss by fire, water, storm, theft, strikes and other emergencies of that character, but does not guarantee or insure the Exhibitor against loss by reason thereof.

Cooperation of Exhibitor Requested.—The foregoing regulations with reference to exhibits have been formulated for the best interests of exhibitors and the hearty cooperation of our patrons is requested. All points not covered are subject to settlement by the management.

Space is leased with the understanding that the Exhibitor will bold the Florida Medical Association, Inc., harmless from any or all liability which results from any cause whatsoever within the control of said Exhibitor.

Application for SPACE in the

Technical Exhibit

at the Sixty-Fourth Annual Meeting

of

Florida Medical Association, Inc.

VINOY PARK HOTEL

ST. PETERSBURG, FLORIDA

APRIL 5, 6 AND 7, 1937

FLORIDA MEDICAL ASSOCIATION, Inc.
Box 1018
Jacksonville, Florida

You are hereby authorized to reserve for our use space in the Technical Exhibit at the Vinoy Park Hotel for the Sixty-fourth Annual Meeting of the Florida Medical Association, Inc., April 5, 6 and 7, 1937.

Our First Choice is Space No.....; at $.....

Our Second Choice is Space No.....; at $.....

Our Third Choice is Space No.....; at $.....

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(Make four selections. Space will be assigned in the order in which contracts are received.)

TERMS—Fifty per cent of contract price March 1st, and the balance to be paid on or before March 15, 1937.

Firms purchasing two or more spaces will be allowed a 15% discount. Space purchased by one firm must be used exclusively by that firm and subletting of space is prohibited.

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(Print here two-line copy for your identification sign.)

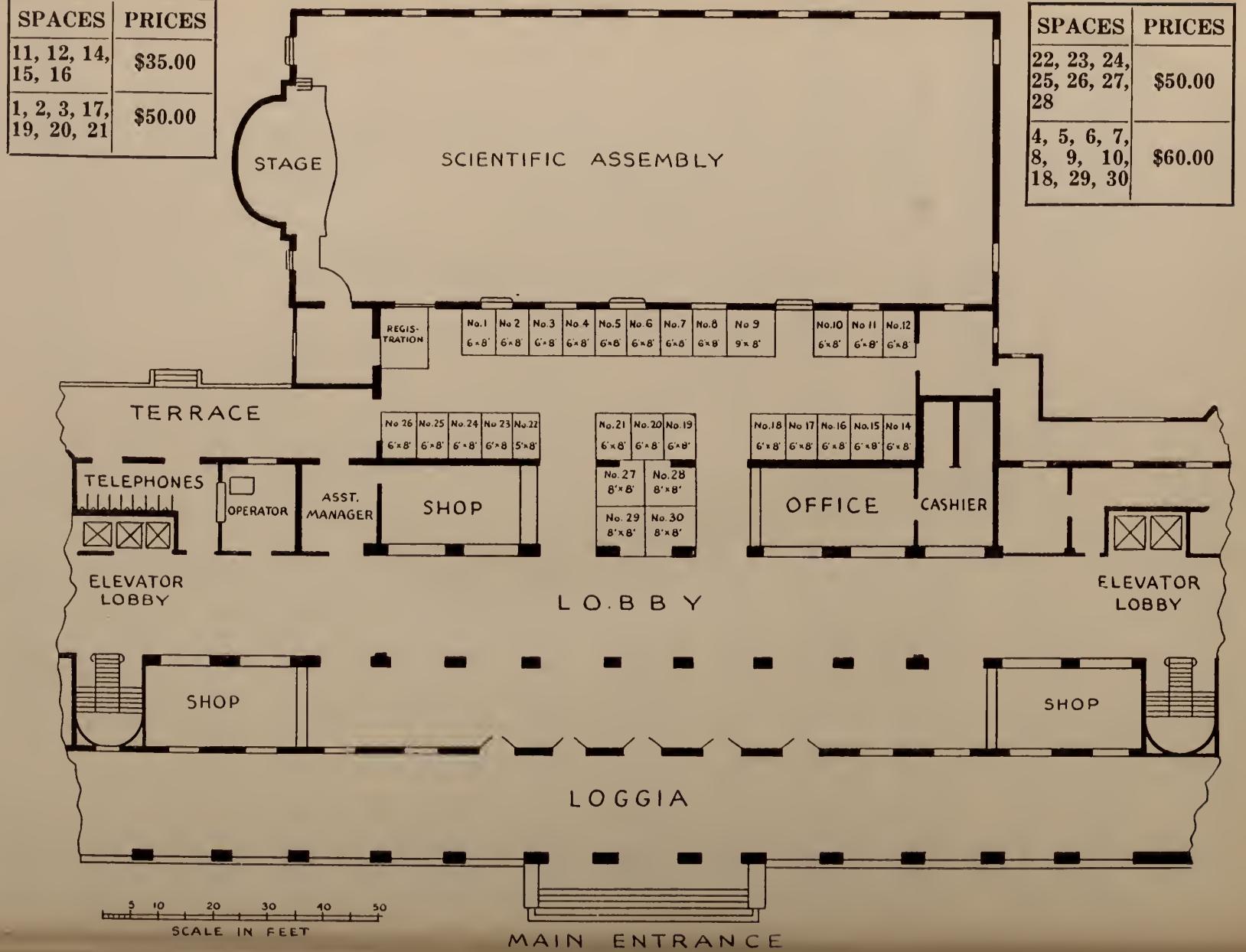
(Sign Painter's Copy)

SCHEDULE OF EXHIBIT SPACES AND PRICES

St. Petersburg, Florida, 1937

SPACES	PRICES
11, 12, 14, 15, 16	$35.00
1, 2, 3, 17, 19, 20, 21	$50.00

SPACES	PRICES
22, 23, 24, 25, 26, 27, 28	$50.00
4, 5, 6, 7, 8, 9, 10, 18, 29, 30	$60.00



Florida Medical Association, Inc.

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(Terms expire after A.M.A. meeting, 1936)

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(Address all communications to Box 1018, Jacksonville)



MORRIS FISHBEIN, M.D., OUR HONOR GUEST

Dr. Morris Fishbein was born in St. Louis, July 22, 1889. He is editor of the Journal of the American Medical Association; editor of Hygeia, the Health Magazine; associate clinical professor of medicine, University of Chicago; lecturer on history of medicine, University of Illinois; member of the Council on Pharmacy and Chemistry, the Council on Physical Therapy, the Council on Scientific Assembly, and chairman of the Committee on Foods of the American Medical Association. He is author with Dr. George H. Simmons of "The Art and Practice of Medical Writing"; author with Dr. Oliver T. Osborne of the "Handbook of Therapy"; editor of "Your Weight and How to Control It"; editor with Dr. William A. White of "Why Men Fail" and "Modern Medical Home Adviser". He is also author of "The Medical Follies", "The New Medical Follies", "Shattering Health Superstitions", "The Human Body and Its Care", "An Hour on Health", "Doctors and Specialists", and "Fads and Quackery in Healing". He has made many significant contributions to medical and lay literature, his most recent articles appearing in the Saturday Evening Post. Dr. Fishbein is editor of the Bulletin of the Society of Medical History of Chicago. He is a member of the American Public Health Association, Chicago Pathological Society, Institute of Medicine, American Association for the Advancement of Science, and a Fellow of the American Medical Association. He is a member of the Standard Club, Tavern Club and the Quadrangle Club. Dr. Fishbein conducts a health column syndicated by NEA service in over two hundred newspapers.

Dr. Fishbein received his B.Sc. degree from the University of Chicago in 1910, and his M.D. degree from Rush Medical College in 1912. At the time of graduation, he received the Alumni Fellowship in Pathology and became associated with Drs. Ludvig Hektoen and E. R. LeCount, publishing several papers of a medical research character. He also served as house physician in the Durand Hospital of the McCormick Institute for Infectious Diseases, 1912-1913. In August, 1913, following the death of Dr. E. R. Hyde, he became assistant to Dr. George H. Simmons, editor of the Journal of the American Medical Association, which position he held up to 1924, when he was elected editor to succeed Doctor Simmons.

The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018, Jacksonville, Fla. Telephone 5-0577

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HOUSE OF DELEGATES

One delegate for each twenty members, or major fraction thereof, is allowed each component society as its representation in the House of Delegates. The basis used in determining the number of delegates to which a society is entitled is the number of paid members of that society whose 1937 dues have been paid to the treasurer of the State Association. Members whose dues for 1937 have not been paid cannot be counted in seating delegates. Each society should select its delegate, or delegates, with care as there undoubtedly will be some very important matters brought up before the House of Delegates.

The Executive Committee took action at a recent meeting, requiring delegates to have credentials from the officers of their component societies. Each delegate is requested to present his credentials at the registration desk immediately upon arrival in St. Petersburg. In this way, the roster of delegates may be checked and unnecessary confusion avoided in seating the delegates when the meeting opens. Printed forms to be used as credentials have been placed in the hands of the secretary of each component society. Each delegate should, therefore, secure his credentials before leaving home.

All meetings of the House of Delegates will be held in the east end of the Ball Room of the Vinoy Park Hotel. The first meeting is scheduled for Monday, April 5, at 7:00 p. m. All delegates will be seated in a reserved space entirely separate from any members who may wish to attend the meeting as visitors.

ABSTRACT DEPARTMENT

Beginning with this issue, the editors have decided to run a current review or abstract department in the Journal. These abstracts will be confined entirely to publications of members of the Florida Medical Association and to those publications which appear in Journals other than the Journal of the Florida Medical Association. A recent review of the literature reveals a surprising number of articles by Florida men.

The purpose of this department is to show recognition and to stimulate the writing of more papers by Florida men. Also, considerable valuable information should be obtained from these abstracts.

The first group of abstracts appear in this issue, following component society news.

MEMBERS-ELECT OF THE LEGISLATURE OF 1937, STATE OF FLORIDA

(Compiled by R. A. Gray, Secretary of State)

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District 25—Joe Sharit, Port St. Joe*
District 26—H. S. McKenzie, Palatka**
District 27—H. G. Murphy, Zolfo Springs*
District 28—F. B. Nordman, Jr., Daytona Beach**
District 29—J. D. Dugger, Macclenny*
District 30—R. S. Adams, Jasper**
District 31—Peter Kendrick, St. Augustine*
District 32—R. Lucas Black, Gainesville**
District 33—A. O. Kanner, Stuart*
District 34—Henry Tillman, Tampa**
District 35—John R. Beacham, West Palm Beach*
District 36—Wallace Tervin, Bradenton**
District 37—J. J. Parrish, Titusville*
District 38—Fred L. Touchton, Dade City**

* Nominated in 1936.

** Hold-overs.

*** Nominated to fill unexpired term of H. H. Lewis, Deceased.

**** Elected Nov., 1936, to succeed John S. Taylor, Deceased.

HOUSE OF REPRESENTATIVES

Alachua—Fred D. Bryant, Gainesville
Alachua—J. C. (Jap) Harris, LaCrosse
Baker—Edwin G. Fraser, Macclenny
Bay—Carl Gray, Millville
Bay—H. L. Sudduth, Panama City
Bradford—Fred Hazen, Brooker
Brevard—Noah B. Butt, Cocoa
Broward—Dwight L. Rogers, Ft. Lauderdale
Broward—Roe Fulkerson, Hollywood
Calhoun—J. Frank Adams, Blountstown
Charlotte—J. T. Rose, Jr., Punta Gorda
Citrus—Lovick P. Williams, Inverness
Clay—J. Slater Smith, Green Cove Springs
Collier—W. Z. Platt, Everglades
Columbia—Norman P. Ives, Lake City
Dade—George E. Holt, Miami
Dade—John J. Lindsey, Miami
Dade—H. E. Overstreet, Miami
DeSoto—J. L. Dishong, Arcadia
Dixie—W. P. Chavous, Cross City
Duval—W. McL. Christie, Jacksonville
Duval—W. A. (Spic) Stanly, Jacksonville
Duval—John M. King, Jacksonville
Escambia—John W. Cole, Pensacola
Escambia—Webb C. Jernigan, Pensacola
Flagler—H. T. Cook, Bunnell
Franklin—R. Don McLeod, Apalachicola
Gadsden—Amos H. Davis, Mt. Pleasant
Gadsden—E. H. Slappey, Havana
Gilchrist—O. Lamar Crocker, Trenton
Glades—J. H. Peeples, Moore Haven
Gulf—R. Alton Dendy, Port St. Joe
Hamilton—F. B. Harrell, Jasper
Hardee—W. A. Hendry, Ft. Green
Hendry—Elbert L. Stewart, Clewiston
Hernando—M. A. Coogler, Brooksville
Highlands—Dr. A. T. Eide, Lake Placid
Hillsborough—E. P. Martin, Plant City
Hillsborough—Raymond Sheldon, Tampa
Hillsborough—Seth Dekle, Tampa
Holmes—A. P. Drummond, Bonifay
Indian River—Eli C. Walker, Vero Beach
Jackson—C. L. Alford, Grand Ridge
Jackson—J. Troy Peacock, Marianna
Jefferson—C. Parkhill Mays, Monticello
Lafayette—E. S. Winburn, Mayo
Lake—John L. Fahs, Leesburg
Lake—Thomas H. Cooley, Mt. Dora
Lee—Wm. J. Wood, Ft. Myers
Leon—LeRoy Collins, Tallahassee
Leon—Walter T. Moore, Jr., Tallahassee
Levy—Halley B. Lewis, Williston
Liberty—G. P. Wood, Vilas, R. F. D., Quincy
Madison—W. L. Gaston, Madison
Madison—David Lanier, Madison
Manatee—Ben H. Fuqua, Palmetto
Manatee—William J. Ray, Bradenton
Marion—A. P. (Sam) Buie, Ocala
Marion—W. E. Smith, Ocala
Martin—Evans Crary, Stuart
Monroe—B. C. Papy, Key West
Nassau—Dan Kelly, Jr., Fernandina
Okaloosa—Robert F. Sikes, Crestview
Okeechobee—W. W. Potter, Okeechobee
Orange—Robert L. Hodges, Orlando
Orange—L. C. Leedy, Orlando
Osceola—Velton (Doc) Walters, Kissimmee
Palm Beach—Russell O. Morrow, Lake Worth
Palm Beach—Paul Rardin, Canal Point
Pasco—John S. Burks, Dade City
Pinellas—W. D. Outman, St. Petersburg
Pinellas—Walter P. Fuller, St. Petersburg
Pinellas—Archie Clement, Tarpon Springs
Polk—J. P. Marchant, Lakeland
Polk—Henry M. Sinclair, Winter Haven
Polk—E. Snow Martin, Bartow
Putnam—Victor Motes, Interlachen
Putnam—T. C. Douglas, Welaka
St. Johns—J. H. Turner, St. Augustine
St. Johns—Harry H. Saunders, St. Augustine
St. Lucie—Dan McCarty, Ft. Pierce
Santa Rosa—T. Franklin West, Milton
Sarasota—John L. Early, Sarasota
Seminole—H. J. Lehman, Sanford
Seminole—Gordon Barnett, Fern Park
Sumter—J. C. Getzen, Jr., Bushnell
Suwannee—M. A. Best, Branford
Suwannee—J. P. Hatch, Live Oak
†Taylor—J. H. Scales, Perry
Union—Ernest Hewitt, Lake Butler
Volusia—Caspian Hale, New Smyrna
Volusia—John S. Byington, Daytona Beach
Wakulla—Angus Morrison, Crawfordville
Walton—S. M. Preacher, DeFuniak Springs
Washington—W. C. Godwin, Chipley

† Elected February, 1937, to succeed W. T. Hendry, Deceased.

POSTGRADUATE SHORT COURSE

The program has been recently completed for the Fifth Annual Short Course for Doctors of Medicine in Florida, which will be held at the Orange Court Hotel, Orlando, June 21-26, inclusive. The courses and instructors are as follows:

Medicine—Dr. Walter L. Bierring, Des Moines, Iowa.

Surgery—Dr. W. Emory Burnett, Temple University, Philadelphia, Pa.

Obstetrics—Dr. J. O. Arnold, Temple University, Philadelphia, Pa.

Pediatrics—Dr. A. J. Schaffer, Johns Hopkins School of Medicine, Baltimore, Md.

Gynecology—Dr. Bayard Carter, Duke University, Durham, N. C.

Neuropsychiatry—Dr. Ralph N. Greene, Coral Gables, Fla.

The official programs of the short course will be available at the Florida Medical Association Convention, April 5, 6, and 7. Further details concerning the instructors will be published in subsequent issues of the Journal.

FLORIDA MIDLAND MEDICAL SOCIETY

The Florida Midland Medical Society will hold its Spring Meeting at the Dixie Grande Hotel, Bradenton, April 29, beginning at 2:00 p. m. The tentative program for this meeting is as follows:

1. "Differential Diagnosis of Acute Abdominal Conditions", John T. Moore, Tampa.
2. "Results of Elliott Treatment in 33 Cases", Howard Weems, Sebring.
3. "Modern Medicine in Ancient Iran", Rosalie Slaughter Morton, Winter Park.
4. "The Diagnosis of Some Common Contagious Diseases of the Skin", Louis B. Mount, St. Petersburg.
5. "Low Cesarean Section — DeLee" (Illustrated), Benjamin F. Hart, Winter Park.
6. "Tumors of the Lung", Joseph Halton, Sarasota.
7. "The Unusually Placed Appendix", W. D. Sugg, Bradenton.
8. "Infected Abortions—the Pathology and Treatment", Duncan T. McEwan, Orlando.
9. "Pathology, Symptomatology and Diagnosis of Diseases of the Prostate", Gideon Timberlake, St. Petersburg.

At the dinner to be held that evening at 8:00 p. m., Dr. Fred H. Albee of Venice will be principal speaker and give an illustrated address on "Reconstructive Surgery."

The officers of the Florida Midland Medical Society are: C. W. Larrabee, Bradenton, president; Leland F. Carlton, Tampa, first vice-president; W. C. McConnell, St. Petersburg, second vice-president; and B. H. Sanchez, Plant City, secretary-treasurer.

STATE NEWS ITEMS

For the benefit of members and guests registered at the Vinoy Park Hotel, headquarters for the annual meeting in April, there will be no extra cost for the Association Dinner on Tuesday evening. Persons not stopping at the Vinoy Park Hotel at the American Plan rate will have to pay for their Tuesday evening Dinner tickets.

* * *

Dr. William G. Doern of Daytona Beach is in Milwaukee, continuing his research work on cancer.

* * *

Dr. T. A. Neal of Orlando announces the removal of his offices from 356 N. Orange Avenue to 11 Lucerne Circle in the Orange Clinic.

* * *

Dr. H. J. Blackmon of Tampa spent the first two weeks of March in Philadelphia, where he took eye, ear, nose and throat work under Dr. G. W. MacKenzie.

* * *

Dr. A. B. Quasser of Jacksonville recently attended the Graduate Medical Assembly held at New Orleans.

* * *

The work of fourteen committees of the Pinellas County Medical Society is practically completed. They are prepared to entertain the convention in a big way.

* * *

The Committee on Medical Postgraduate Course has completed the program for the Fifth Annual Short Course for Doctors of Medicine in Florida. The largest enrolment to date is expected at the Short Course to be held in Orlando June 21-26.

Dr. Lawrence A. Klein of Live Oak was awarded a Fellowship in the International College of Anesthetists at a recent meeting in Philadelphia. He is the only Florida member of the American Society of Anesthetists.

* * *

Dr. John J. Bourke, formerly of Dade City, has given up his private practice there to accept a position with the New York State Department of Health, Albany, N. Y.

* * *

The twenty-first quarterly meeting of the Florida Society of Dermatology and Syphilology was held in Miami on February 21. The clinic was held in the morning and a number of interesting cases were presented for diagnosis and discussion. Guests present were: Dr. E. R. Maloney, Associate Professor of Dermatology and Syphilology at New York University; Dr. Rothwell Lefholz, Miami. Members present were: Drs. J. Lee Kirby-Smith, Alan Brown, Frank Wilson and L. M. Sompayrac of Jacksonville; Dr. S. F. Ricker of Orlando; Dr. J. A. Newnham, W. Palm Beach; Dr. C. A. Andrews, Tampa; and Drs. Elmo French, Buist Litterer, George N. MacDonell, and Wiley M. Sams, Miami.

* * *

The Centennial of the University of Louisville Medical School will be celebrated March 31 to April 3, 1937, at Louisville, Ky. The Alumni are urged to make their plans to attend their alma mater and participate in the celebrations. There will be much of interest in the way of clinical programs, scientific exhibits and entertainment.

* * *

The Fifth International Congress of Hospitals will be held in Paris, France, July 6-11, 1937.

* * *

Dr. J. M. Grantham, of Tampa, a member of the Florida Medical Association and a life member of the Hillsborough County Medical Society, died February 26, 1937.

* * *

There will be no extra cost for the Association Dinner Tuesday evening, April 6 at the Vinoy Park Hotel, St. Petersburg, for members who are guests of that hotel. All persons not stopping at the Vinoy Park Hotel who wish to attend the Association Dinner, Tuesday evening, must purchase tickets.

The Eighth Annual Session of the Southeastern Surgical Congress was held at Charlotte, March 8-10. Dr. Edward Jelks of Jacksonville and Dr. Arthur Weiland of Coral Gables both read papers at the meeting. Among other Florida members in attendance were Dr. J. S. Turberville of Century, Dr. J. C. Davis of Quincy, Dr. Ralston Wells of Daytona Beach, Dr. William Lancaster of Tampa, Dr. J. L. Hargrove of Bartow, Dr. A. M. Ames of Pensacola, and Dr. Gerry R. Holden, Jacksonville.

JAMES HARRISON HODGES

Dr. James Harrison Hodges, of Gainesville, who died February 3, 1937, was an outstanding member of the medical profession for many years.

He was a native Floridian, having been born at Worthington Springs, June 16, 1866. He was educated at the East Florida Seminary, now the University of Florida and, later, received his medical degree from the University of Maryland. Following his graduation in medicine he was appointed chief house physician at the Good Samaritan Hospital, Baltimore. A year later he was offered the position of resident physician and superintendent of St. Luke's Hospital, Jacksonville, and served in this capacity until he resigned to engage in private practice. His success was immediate and he enjoyed a very large practice.

His talents were quickly recognized and honors came to him unsolicited. He served as president of the Florida Medical Association and frequently represented his State Association at the annual meetings of the American Medical Association. The late governor Broward appointed him a member of State Board of Medical Examiners.

Doctor Hodges was always keen to keep abreast of modern medical knowledge and took frequent post-graduate courses in the medical centers of this country and abroad. He was a great lover of travel, visiting every part of the United States and many foreign countries. He and Mrs. Hodges were in Europe at the outbreak of the World War and had some exciting experiences in getting back across the Atlantic to this country.

He has reflected honor on the medical profession and his quiet, affable and studious habits gained for him many friends.

JOHN MILLER BEGGS

Dr. John Miller Beggs was born January 9, 1889, at Boston, Georgia.

In 1908 he entered the University of Georgia, was there three years for pre-medical work. He graduated in 1914 from Atlanta School of Medicine, now Emory University, and served his internship at Pensacola Hospital, Pensacola, Fla., 1915-1916. He was the first intern to serve in the Pensacola Hospital.

After finishing his internship, Doctor Beggs did general practice in Pavo, Georgia, until 1917 when he enlisted in the World War in which he served as Captain in the Medical Corps. He was overseas 18 months, and after the Armistice remained there with the Army of Occupation for nine months. After his return from overseas he did general practice in Pavo and then, in 1923, he moved to River Junction, Florida, and did general practice there.

In 1925 he became a member of the staff of the Florida State Hospital and for ten years had charge of the x-ray department there, after which, in 1935, he took post-graduate work in x-ray at the Cook County Hospital in Chicago.

Doctor Beggs was a member of the American Medical Association, the Florida Medical Association, the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society and the Radiological Society of North America. He was a member of Ye Mystic Order of The Shrine and of the American Legion.

Dr. Beggs was married in Pavo, Ga., October 28, 1916, to Miss Irene Adams.

He died October 28, 1936, at The Florida State Hospital, Chattahoochee, of carcinoma of the esophagus. He is survived by his wife and one son.

Dr. and Mrs. Louis R. Bowen of Eustis announce the birth of a son, Louis Richard, Jr., on February 24.

PHYSICIAN WANTED—Open field for good practitioner who is looking for a permanent location. Any facilities will be found here that are to be had in any city. Three miles from hospital situated in county-seat. Offices and residence available at once. Write for information or call on us. Arcade Drug Store, E. C. Carlson, Largo, Fla.

COMPONENT COUNTY SOCIETIES

ALACHUA COUNTY MEDICAL SOCIETY

Serving as officers of the Alachua County Medical Society for 1937 are the following Gainesville doctors:

President—T. A. Snow.
First Vice-President—J. E. Maines, Sr.
Second Vice-President—R. E. Summitt.
Sec'y-Treasurer—H. M. Merchant.
Delegate to Convention—J. E. Maines, Jr.
Alternate Delegate—W. C. Thomas.

BAY COUNTY MEDICAL SOCIETY

At a recent meeting of the Bay County Medical Society, the following officers were elected for 1937:

President—D. M. Adams, Panama City.
Vice-President—W. J. Blackshear, Panama City.
Sec'y-Treas.—A. H. Miller, Millville.
State Delegate—J. M. Nixon, Panama City.
Alternate—W. C. Roberts, Panama City.

BREVARD COUNTY MEDICAL SOCIETY

The Brevard County Medical Society held its regular monthly meeting Tuesday evening, February 9, at the New Indian River Hotel in Rockledge. The meeting was one of the most enthusiastic yet enjoyed by this Society. Among the guests who were entertained were Dr. Edward Jelks, President-elect; Dr. Shaler Richardson, Secretary-Treasurer and Editor of the Journal; and Dr. Stewart Thompson, Business Manager, all representing the State Association.

Dr. George W. Fifield of Janesville, Wisconsin, was also a guest. Doctor Fifield is a friend and former colleague of Secretary Dr. Bob Schlernitzauer. Doctor Fifield is widely known in Southern Wisconsin where he has practiced medicine for many years.

The banquet preceding the regular meeting was a very delightful affair. Doctor Jelks gave a most interesting lecture on "The Abnormal Conditions of the Thyroid Gland Calling For Surgical Interference." Doctor Richardson gave an interesting address on "The Meaning and Purposes of the County Society and the State Association with the Newer Conception and Purposes of the Proposed Socialized Medicine."

The meeting was well attended by the Brevard County members. Among those present were

Dr. W. C. Page, president of the society, who presided ably. This was the first meeting since his election. Other members present included Drs. T. C. Kenaston, Bob Schlernitzauer, E. W. Potthoff, T. Lamson, I. F. Bean, I. M. Hay, I. K. Hicks, and W. J. Creel. This first meeting under the new officers was a decided success and the enthusiasm of the members was evidenced throughout.

COLUMBIA COUNTY MEDICAL SOCIETY

At its annual meeting, the Columbia County Medical Society elected officers for 1937, as follows:

President—Thomas H. Bates, Lake City.
Vice-President—W. S. Nichols, Lake City.
Sec'y-Treas.—M. W. Spearman, Lake City.

Drs. T. H. Bates and L. M. Anderson were selected as delegates to the annual convention of the State Association.

DADE COUNTY MEDICAL SOCIETY

At a meeting of the Dade County Medical Society, held at the Jackson Memorial Hospital, February 5 at 8:30 p. m., the following scientific program was given:

"Carcinoma of the Esophagus Treated by X-ray, Now Under Control and Observation," J. Frazier Payton, Miami Beach.

"Acute Pancreatitis with Unusual Past History and Clinical Manifestations", Robert M. Harris, Miami.

"Bartenders' Dermatitis", Wiley M. Sams, Miami.

"A Common Pediatric Problem", Warren Quillian, Coral Gables.

"Uterine Fibroid—Many Clinical Complications Years After Radiation Therapy Had Supposedly Rendered It Inert", John McDonald, Miami.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

THE DeSOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1937. THIS SOCIETY IS HEADED BY:

President—GORDON McSWAIN, ARCADIA.

Secretary—L. W. MARTIN, SEBRING.

The regular meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Jacaranda Hotel, Avon Park, Tuesday evening, February 9. In the absence of the president, Dr. G. S. McKnight of Avon Park presided. The guest speaker of the evening was Dr. McCreary of the State Board of Health who spoke on the cooperation of the county health officer and the medical profession.

DUVAL COUNTY MEDICAL SOCIETY

At a regular meeting of the Duval County Medical Society held at the Seminole Hotel, Tuesday evening, March 2, a symposium on "Chills and Fever" comprised the scientific program. The following papers were presented:

"Caused by Conditions in the Chest", L. V. Tyler.

"Caused by Conditions in the Upper Abdomen", R. R. Killinger.

"Caused by Conditions in the Lower Abdomen", E. W. Veal.

"Caused by Malarial and Other Fevers", H. W. Porter.

"Caused by Conditions in Bones and Joints", Charles Mabry.

"Indicated Laboratory Examinations", L. Y. Dyrenforth.

Plans for the enlargement of the Duval County Hospital and for the allocation of funds for the indigent sick as now being worked out by the Duval County Welfare Board were then considered. The plan for enlargement of the County Hospital originated with the Society about a year ago.

HILLSBOROUGH COUNTY MEDICAL SOCIETY

The following resolutions on the death of Dr. J. M. Grantham were unanimously passed by the Hillsborough County Medical Society at a meeting held on March 2:

Whereas, the Hillsborough County Medical Society has suffered in the sudden and untimely death of Dr. J. M. Grantham a most valuable, stalwart, respected and beloved member, and

Whereas, Dr. J. M. Grantham has always been a true disciple of the principles of organized medicine which he has practiced as well as preached, always maintaining the highest standard of ethical relationship with his brother practitioners, and

Whereas, Dr. J. M. Grantham has always maintained an intensive and active interest in organized medicine by his outstanding work in the Hillsborough County Medical Society in which organization he has held every official position, and

Whereas, Dr. J. M. Grantham has been most energetic in his care for service and charity patients, never considering the financial returns of his work from any patient but has been interested only in results, and

Whereas, as a citizen Dr. J. M. Grantham has been an outstanding leader in all civic movements and enterprises and a constructive force in the development of Tampa as a medical center,

BE IT THEREFORE RESOLVED, That the Hillsborough County Medical Society feels the loss of this member very deeply and that each member of the Society is grieved.

BE IT FURTHER RESOLVED, That the Hillsborough County Medical Society offers condolence to the family of this departed member and that a copy of these resolutions be sent to his bereaved widow and family.

(Signed) GEO. L. COOK,
President.

Attest: JAMES S. GRABLE,
Secretary.

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society has elected the following officers to serve for the ensuing year:

President—L. H. Oetjen, Leesburg.
Vice-President—H. T. Fenn, Mt. Dora.
Sec'y-Treas.—W. L. Ashton, Umatilla.
Delegate to State Association—R. H. Williams, Eustis.
Alternate—M. M. Hannum, Eustis.

LEE COUNTY MEDICAL SOCIETY

The Lee County Medical Society is this year headed by the following officers:

President—H. Quillian Jones, Ft. Myers.
Vice-President—Baker Whisnant, Ft. Myers.
Sec'y-Treas.—Harvie J. Stipe, Ft. Myers.
Delegate to State Meeting—Harvie J. Stipe.
Alternate Delegate—M. F. Johnson, Ft. Myers.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

At the annual meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, the following officers were elected to serve for 1937:

President—L. L. Dozier, Tallahassee.
Vice-President—W. D. Rogers, Chattahoochee.
Sec'y-Treas.—B. A. Wilkinson, Tallahassee.

MADISON COUNTY MEDICAL SOCIETY

THE MADISON COUNTY MEDICAL SOCIETY IS IN THE GROUP OF SOCIETIES WHO HAVE REPORTED 100% OF MEMBERSHIP DUES PAID FOR 1937. DR. EUSTACE LONG OF MADISON IS PRESIDENT AND DR. GEORGE O. DAVIS OF MADISON IS SECRETARY FOR 1937.

MANATEE COUNTY MEDICAL SOCIETY

THE MANATEE COUNTY MEDICAL SOCIETY, WITH A MEMBERSHIP OF ELEVEN, IS 100% PAID FOR 1937. THIS SOCIETY IS HEADED BY:

President—L. W. BLAKE, BRADENTON.
Sec'y-Treas.—M. M. HARRISON, BRADENTON.

CONGRATULATIONS, MANATEE COUNTY SOCIETY.

PALM BEACH COUNTY MEDICAL SOCIETY

At the election of officers held by the Palm Beach County Society recently, the following were elected:

President—Bailey B. Sory, Jr., W. Palm Beach.
Vice-President—Wilbur O. Arnold, W. Palm Beach.
Secretary—Lloyd J. Netto, W. Palm Beach.
Treasurer—F. K. Herpel, W. Palm Beach.

Drs. F. K. Herpel, W. L. Shackelford and W. O. Arnold were chosen to represent the society at the House of Delegates of the Florida Medical Association.

PINELLAS COUNTY MEDICAL SOCIETY

At a recent meeting of the Pinellas County Medical Society the following members were elected to serve as delegates to the annual meeting of the State Association: N. M. Marr, W. C. McConnell, C. A. Williams and A. J. Wood. The alternate delegates chosen were: Earl C.

MacCordy, William M. Davis, George E. Miller and F. E. Kauffman.

The feature at the February 19 meeting of the Society were two motion picture reels on "Treatment of Pneumonia" and "Treatment of Pernicious Anemia." "A Talk on Obstetrics" by Dr. S. P. Smiseth was the principal paper on the program for the March 5 meeting of the Society.

ST. JOHNS COUNTY MEDICAL SOCIETY

Serving as officers of the St. Johns County Medical Society for 1937 are:
President—C. C. Grace, St. Augustine.
Vice-President—W. D. Webb, St. Augustine.
Secretary—R. D. Harris, St. Augustine.
Treasurer—A. C. Walkup, St. Augustine.

Drs. Reddin Britt and A. C. Walkup will represent this society in the House of Delegates at the St. Petersburg meeting.

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY

The St. Lucie-Okeechobee-Indian River-Martin County Medical Society elected the following officers at its annual meeting:
President—H. D. Clark, Ft. Pierce.
Vice-President—R. C. Boothe, Ft. Pierce.
Sec'y-Treas.—Grover C. Hardie, Ft. Pierce.
Delegate to State Association—A. M. Sample, Ft. Pierce.
Alternate Delegate—E. B. Hardee, Vero Beach.

SEMINOLE COUNTY MEDICAL SOCIETY

SEMINOLE COUNTY MEDICAL SOCIETY HAS REACHED THE HONOR ROLL OF SOCIETIES WHICH ARE 100% PAID FOR 1937. THIS SOCIETY HAS TWELVE MEMBERS AND IS HEADED BY:
President—H. D. SMITH, SANFORD.
Vice-President—J. N. TOLAR, SANFORD.
Sec'y-Treas.—D. G. SCOTT, SANFORD.

DRS. J. T. DENTON AND G. S. SELMAN WILL REPRESENT THE SOCIETY AT THE MEETING OF THE HOUSE OF DELEGATES IN ST. PETERSBURG.

SUMTER COUNTY MEDICAL SOCIETY

SUMTER COUNTY MEDICAL SOCIETY, AS USUAL, IS 100% PAID EARLY IN THE YEAR. THOUGH SMALL IN MEMBERSHIP, THIS SOCIETY HAS BEEN A STAUNCH PART OF THE ASSOCIATION FOR MANY YEARS. ITS OFFICERS ARE:
President—A. B. ALBRITTON, WILDWOOD.
Vice-President—C. L. CARTER, WILDWOOD.
Secretary—W. E. MITCHELL, BUSHNELL.
Delegate to State Meeting—S. C. WOOD, LEESBURG.

TAYLOR COUNTY MEDICAL SOCIETY

THE TAYLOR COUNTY MEDICAL SOCIETY IS 100% PAID FOR 1937. CONGRATULATIONS! THE OFFICERS OF THIS SOCIETY ARE:
President—G. H. WARREN, PERRY.
Vice-President—J. L. WEEKS, PERRY.
Sec'y-Treasurer—J. C. ELLIS, PERRY.
Delegate to State Meeting—G. H. WARREN.
Alternate Delegate—J. L. WEEKS.

VOLUSIA COUNTY MEDICAL SOCIETY

At the annual meeting of the Volusia County Medical Society, the following officers were chosen for 1937:
President—J. Ralston Wells, Daytona Beach.
Vice-President—Hugh West, DeLand.
Sec'y-Treas—R. L. Miller, Daytona Beach.

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY IS ONE OF A GROUP OF SOCIETIES WHICH THE STATE ASSOCIATION CAN DEPEND UPON TO BE 100% PAID AT LEAST THIRTY DAYS BEFORE THE TIME OF THE ANNUAL CONVENTION. THIS SOCIETY WITH ITS SCATTERED MEMBERSHIP IS WORTHY OF COMMENDATION FOR THE PROMPTNESS WITH WHICH IT SUBMITS ITS REPORT. SERVING AS OFFICERS OF THE SOCIETY FOR THIS YEAR ARE:
President—A. G. WILLIAMS, LAKEWOOD.
Vice-President—S. E. STEPHENS, LAUREL HILL.
Sec'y-Treas.—R. B. SPIRES, DeFUNIAK SPRINGS.
Delegate to Annual Convention—S. E. STEPHENS.
Alternate Delegate—R. E. ENZOR, CRESTVIEW.

ABSTRACT DEPARTMENT

Kenneth A. Morris, M.D., Abstract Editor

The Toxic Effect of Quinine On the Eye— RICHARDSON, SHALER, Jacksonville, Florida—*S. M. J.*, Vol. 29, No. 12, 1156 (December) 1936.

The author does not indict the use of quinine, but feels obligated to point out the complications affecting the eye which occasionally arise from its use. He believes that "it is through the recognition of ocular idiosyncrasies to this drug and the discontinuance of its use that mitigation of damage to the eye may be obtained."

Amblyopia ascribable to quinine is reviewed in the literature. Since 1841 over 200 cases have been recorded. Two cases are reported in infants whose mothers had had quinine for diseases concurrent with pregnancy and for the purpose of producing labor. Seven cases are reported in which quinine was administered directly to the patient.

The most important consideration is the early recognition of the condition and the discontinuance of the use of the drug. In the nine cases reported, the findings are similar to those of most other authors. In two of the cases the author suggests the use of quinine in prenatal medication as an etiological factor. Animal experiments indicate "that the toxic effect of quinine on the ganglion cells of the retina is the primary cause of damage to the eye and that the vasoconstriction of the retinal vessels is a secondary factor." The use of vasodilator drugs such as nitroglycerine and nitroscleran, hypodermically and intravenously, is recommended. "Sympathectomy, as used in retinitis pigmentosa, is suggested in the treatment of patients in whom contraction of the visual fields and reduced vision persists."

The Treatment of Otitis Media By the Roentgen Ray— LUCINIAN, JOSEPH H., Miami, Florida—*A. J. of Roent.*, Vol. 36, No. 6, 946 (December) 1936.

Uniformly favorable results obtained by roentgen treatment in inflammatory processes forms the basis for the treatment of acute, sub-acute or chronic otitis media and mastoiditis by the roentgen ray. The author employs the following technique: "100 to 110 kv.; 16-inch distance; 2 mm. aluminum; 5 ma.; five minutes; a tube with a broad disk for target with an output of 14.3 roentgens per minute; the total dose is 71.5 r, measurements taken in air. This is the equivalent of about 15 to 20 per cent of the erythema dose." A series of fifty consecutive cases of otitis media and mastoiditis were treated during the past several years. Symptoms associated with chronic otitis media were improved or eradicated. Twenty-five unselected cases of acute and chronic otitis media in which x-ray treatment was not given required tympanotomy in eleven, and mastoidectomy in five. Perforation of the drum occurred in five and mastoiditis developed in nine.

"Fifty cases of otitis media (31 acute, 8 subacute, 11 chronic) were given roentgen therapy over the ear and mastoid area. The treatment was consistently followed by relief of pain, increased discharge, improved hearing and amelioration of the systemic manifestations of the disease. After the treatment none of the acute cases developed mastoiditis or perforation of the drum, and none of them required tympanotomy. Mastoiditis was already present when the rays were applied in nine cases, two of which later required mastoidectomy."

The Comprehensive Management of Delirium Tremens— PIKER, PHILIP, Cincinnati, Ohio, and COHN, JESS V., Hollywood, Florida—*J. A. M. A.*, Vol. 108, No. 5, 345 (January 30) 1937.

Three hundred consecutive cases admitted to the Cincinnati General Hospital from Jan. 1, 1933, to July 1, 1935, are reported. The sole prerequisite for cases included was the definite diagnosis of active delirium tremens, regardless of what other pathological process was present. The treatment is discussed under five main heads: (1) The safeguarding of the patient against injury to himself or to others. Constant observation is necessary, but impossible outside of an "adequately equipped and staffed hospital." (2) Prevention of exhaustion. The authors believe that "the main causes of death in uncomplicated delirium tremens is heart failure, both of itself and indirectly because of toxicity and impairment of organ function generally that is incident to an inadequate circulation." Routine complete digitilization of the patient is carried out. It is believed that this part of the treatment considerably reduces the mortality and is of little avail after signs of heart failure have become manifest. Second in importance in the prevention of exhaustion is sedation. Paraldehyde was found to be the most effective and the safest drug available. It is administered orally and rectally

and rapidly eliminated. Lumbar puncture is also done routinely and repeated in 48 hours if there are no signs of improvement. Intravenous 50% dextrose promotes rest by reducing intracranial pressure. They believe that morphine is contraindicated because it increases intracranial pressure. (3) The promotion of elimination. A single dose of cascara followed by daily doses of magnesium sulphate is recommended. (4) The decrease of intracranial edema and pressure. (5) The promotion of adequate nutrition.

The patient is "discharged from the hospital when his delirium has ceased, his tremor is absent or markedly diminished, his apprehensiveness has disappeared, his appetite is definitely improving, his general physical condition is such as to permit him to be ambulatory, and he is able to obtain a good night's sleep without, or with, a minimum sedative aid." The cases reported were treated with a mortality of 5.3% and an average stay in the hospital of 4.8 days.

Benign Lesions of the Breast Diagnosed and Treated as Carcinoma—MURPHEY, DAVID R., JR., Tampa, Florida—*S. M. J.*, Vol. 30, No. 1, 44 (January) 1937.

In a previous report in 1934, the author, in conjunction with Gentile and Lehman, reported 152 cases between 1905 and 1928 which were diagnosed as carcinoma; 17 of these were considered benign. "Of the entire group, 63 could be adequately followed, and of these, eight (12.5%) belong to the group of 17 considered benign. The present report presents a clinical and pathological review of 7 of these 8 cases." Of the 8 cases reviewed, all are alive at the end of 5 years except one who died as a result of an operative infection.

The pathological diagnoses made originally were by well-trained pathologists in a university. It probably represents a knowledge of breast pathology current at the time the diagnoses were made.

The authors point out that "it is essential that the pathologist understand physiological changes if errors are to be avoided in the interpretation of the pathological material." Three cases were diagnosed as lactating breasts which were originally diagnosed and treated as adenocarcinoma with secondary infection. "The hyperplasia of the lactating epithelium was apparently mistaken for carcinoma." Two cases were re-diagnosed as chronic cystic mastitis with duct papilloma which were originally diagnosed as intracystic papillary adenocarcinoma. Two cases were re-diagnosed as benign papilloma which were previously diagnosed as adenocarcinoma and papillary adenocarcinoma respectively. Confusing hyperplastic and anaplastic changes caused the error in the original diagnosis. The authors advise that "in those cases atipical clinically and macroscopic, the quick section also usually presents an atipical appearance." They believe that it is less radical to withhold mastectomy until permanent sections are studied than to subject patients to possibly needless mutilating operations. They expressed the opinion that the quick section method should merely be regarded as a laboratory aid, not as a final opinion.

The Curve of Phenolsulphonphthalein Elimination in Unilateral Kidney Disease—SHAW, E. C., and MCKENZIE, JACK A., Miami, Florida—*S. M. J.*, Vol. 30, No. 1, 61 (January) 1937.

Because the records of the Brady Urological Clinic of the Johns Hopkins Hospital twelve years ago showed the 'phthalein test, as estimated by elimination of the dye in one-hour and two-hour urine specimens, failed in many instances to give an accurate picture of renal efficiency, the authors studied 'phthalein elimination in association with other function tests in various types of kidney disease to modify the technique so that it would reflect more adequately the changes in renal efficiency. They "found that the curve of elimination of the dye was of far greater importance than the quantitative output." Practically all types of kidney diseases were studied. They suggest "the comparison of fractionally collected specimens be termed 'the 'phthalein elimination curve' rather than 'the 'phthalein test.'"

In all cases the dye was administered intravenously in 6 mg. doses. "The curve in the normal is characterized by an elimination of 'phthalein in the first fifteen-minute period approximately equal to the total of the percentages eliminated in the remaining seven periods, and the dye in each specimen after the first is approximately half of that in the preceding period. The earliest departure from normal renal efficiency is indicated by a decrease in dye elimination in the first fifteen-minute specimen with a corresponding increase in the later specimens. As renal failure advances, the peak of elimination shifts from the first to the second

period, and in severe failure to the third period." Inflammatory processes delayed elimination of the dye and impaired circulation and tissue destruction reduced the total output. They conclude that these tests give an index of kidney efficiency and information as to the type and localization of the pathological process. In other words, it is of diagnostic and prognostic value.

Note: (The reader is referred to the complete article for details as to the method of performing the test.)

Unusual Cartilaginous Tumor Formation of Skeleton—FREUND, E., Venice, Florida—*Arch. Surg.*, Vol. 33, p. 1054 (December) 1936.

Freund reports four cases of cartilaginous tumor of the skeleton, which represent in part unusual forms of otherwise well known conditions (enchondroma, single osteochondroma and multiple cartilaginous exostoses) and in part an apparently rare form of a multiple intra-articular tumor formation which, to his knowledge, has not yet been described. There is one case of a true intra-articular osteochondroma, which developed in more than one joint on the basis of a peculiar hyperplastic change of joint cartilage and which had to be differentiated from similar formations as they develop typically in persons with hypertrophic arthritis and from other conditions usually considered neoplastic changes of the joint capsule, such as chondromatosis of the joints. Besides the cartilaginous component, a considerable amount of bony tissue was present. One is justified in speaking of the growth as a cartilaginous tumor, despite the fact that in some instances the bony component is prevalent, mainly because the cartilaginous portion represents the real active element in the tumor, the cellular proliferation of which results in the increase in size. The bony tissue replaces the cartilage; its significance is therefore merely secondary.

Treatment of Acute Empyema—TRAVERS, M. P., Miami Beach, Florida—*A. J. S.*, Vol. 34, No. 1, 50-56 (October) 1936.

"The discussion of some high lights in the development of the treatment of empyema is offered with a desire to focus attention on the efficiency of an operation for its cure." Only the common group of empyemas following respiratory infection is discussed. Six cases in 1934 are reported which had the flap operation of Nicoll and eight cases in 1935 with a modification of the drainage apparatus for use in the flap. "The eight cases done in 1935 with the modified drainage apparatus had an average healing time of four weeks." The drainage apparatus consisted in "a circular piece of rubber dam, one inch in diameter and ten inches long, cemented on one end to the outer flange of the Wilson button and the other end attached to a Paul's tube connecting it to an empty bottle." This modification provided a pathway for pus from the cavity to the drainage bottle without saturating the entire wound. The rubber dam would also close on inspiration as a split finger cot would. "The cases of 1934 and those done previously had an average healing time of five weeks." The author believes that "the flap operation, with the modified drain for empyema . . . gives an adequate and consistent drainage which demands no special postoperative technical care on the ward, is less liable to accidents and is not complicated by chronicity."

Calcium and Vitamin D in Metabolic Processes—S. A. CLARK, Lakeland, Florida—*Medical Record*, Vol. 145, No. 2 (January 20) 1937.

The author states that "normal metabolism with calcium as a factor is largely dependent upon the presence of vitamin D, without which this inorganic inert element does not function. Vitamin D is formed and made available in two ways, first when it is taken as a food adjunct, and second by irradiation either by heliotherapy or by artificial ultraviolet rays." Solar rays stimulate through the skin the formation of vitamin D. Vital resistance has been expatiated on by Rollier of Switzerland who found sunshine of great value in osseous and pulmonary tuberculosis, malnutrition, arthritis, etc. The author believes that "the lessened incidence of respiratory diseases, especially lobar pneumonia and other zymotic diseases, is effected by the increased vital resistance engendered and induced by residence in the semitropics."

Etiology of Lung Abscess—TRAVERS, M. P., Miami Beach, Florida—*Medical Record*, p. 112 (February 3) 1937.

The various theories of the etiology of lung abscess are discussed. The author believes that with aspiration of oral secretions under full anesthesia such a common occurrence, and the incidence of chronic lung abscess being low, the aspiration theory of the etiology of chronic lung

abscess is not logical. He believes that the occurrence of minor embolism as first suggested (Mikulicz-1900) possibly accounts for the production of chronic lung abscesses. These emboli are thought to be infected, or its resultant infarct secondarily infected are aspirated anerobic material.

Sarcoma of the Gall-Bladder, Report of a Case—DYRENFORTH, LUCIEN Y., and JELKS, EDWARD, Jacksonville, Florida—*S. M. J.*, Vol. 30, No. 1, 49 (January) 1937.

The literature is reviewed through 1935. Thirty-four cases have been reported as primary sarcoma of the gall-bladder. A case is reported of a white woman, 72 years of age, upon whom operation was performed and a piece of the gall-bladder wall was removed for microscopic examination. It is pointed out that the condition is usually associated with cholelithiasis and rarely diagnosed before operation.

Bone Chips in Treatment of Osteitis Fibrosa—FREUND, E., Venice, Florida—*J. of Bone and Joint Surg.*, Vol. 19, p. 36 (January) 1937.

Treated seven cases of localized osteitis fibrosa by packing the curetted cavity with chips of bone obtained from the affected limb or, when necessary, from both tibias. The use of bone chips was found to be superior to simple scraping and the use of caustic substances. The cavity can be filled much more easily with chips than with solid cortical bone grafts, and it seems also that the power of osteogenesis is greater with the use of chips. Giant-cell tumors are not so susceptible to this form of treatment, especially if they are in the more advanced stage and if too great a defect results after the curettage of the tumor tissue. Nevertheless, the author obtained a very good result in one case in which the entire lateral condyle was involved. Care should be taken to fill the defect with the chips as completely as possible. In too advanced cases or in recurrent cases of giant-cell tumor, resection with heavy, bridging, tibial grafts is preferable to the less radical procedures, such as curettage and the use of bone chips, and to the more radical ones, such as amputation and exarticulation.

Members of the Association are urged to send in reprints of articles they have had published in out-of-state Journals.
Reprints for the Abstract Department should be forwarded to the Florida Medical Association, Box 1018, Jacksonville.

TUBERCULOSIS AND PUBLIC HEALTH

The following program has been arranged by the Bureau of Tuberculosis of the State Board of Health and approved by the Florida Medical Association's Committee on Tuberculosis and Health and is now presented to the physicians at large as a preliminary to its inauguration. The Association's Committee is composed of the following members:

M. Jay Flipse, M.D., Chairman, Miami; William C. Blake, M.D., Tampa; Spencer A. Folsom, M.D., Orlando; H. W. Henry, M.D., New Smyrna; J. C. McSween, M.D., Pensacola; Harry F. Watt, M.D., Ocala; Louis R. Bowen, M.D., Eustis.

PROGRAM

The Tuberculosis Department of the State Board of Health in concerned with the *prevention of tuberculosis.* The nature of the disease makes early diagnosis the most important factor in tuberculosis control.

FEATURES:

State X-Ray Unit:

It is believed the high school is the best approach, and the program shall begin in the seventh to twelfth high school grades. These children will be tuberculin tested by the local physicians, or through the medium of the local health organizations, and the Tuberculosis Department will x-ray the chests of all the positive reactors. It is believed advisable to include a similar study of school teachers.

The state intends to leave to the local medical societies the decision as to the degree of active participation of the state unit in their respective communities. The plates will be interpreted by various radiologists throughout the State. *The result of the examination will be reported to the family physician.* In indigent cases having no family physicians the reports will be sent to the local charity authorities. The fact that the result of the examination is communicated to the family through the family physician will bring the medical profession into the control program, and not only will it prove a financial asset to the profession, but it will also prevent the development of any trend toward socialized medicine. Once a diagnosis of pulmonary tuberculosis is made through the State facilities the case is automatically referred to the family physician for treatment, guidance, and follow-up. This work will be done only on the invitation of the local medical societies, and will function only as a diag-

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nostic set-up. It may be possible to transfer funds equivalent to the amount which would be required for the state personnel to carry out the x-ray work of the school program to a local community providing the community will use the funds for a similar purpose and can show that the work is being done in a satisfactory manner by a responsible local "set-up".

Indigent cases requiring an x-ray, such as adult suspects; known cases requiring a follow-up; or any other indigent individuals not included in our school program and for whom the local community is unable to make suitable arrangements, may be included in the program provided investigation has been made to confirm their indigency and the approval of the local medical group has been received.

To facilitate obtaining the desired results of the State program the following features should be organized, controlled, and financed by local communities:

I. WIDE USE OF DIAGNOSTIC FACILITIES

To assure diagnosis of the disease at an early stage when there is still a fair prognosis for the patient and limitation to the degree of dispersion of the infection *diagnostic chest clinics* should be organized in the various counties, which should be fostered and maintained by the *local physicians,* and to which should be referred indigent contact and suspected cases. This measure will furnish each locality with a permanent chest clinic organized and controlled by the local medical society and financed by the local community, which can act as the clearing house for cases to be sent to the State Sanatorium or to local institutions for the care of the tuberculous.

II. SPEEDY TREATMENT OF CASES

Even with the added bed capacity for the care of the tuberculous which our new sanatorium at Orlando will yield we can house only about one-fifth of our cases requiring hospitalization. In an effort to attain the objective of adequate treatment for all cases the State presents the following suggestions:

a. That the local medical groups create county centers for the treatment of suitable cases *(indigent)* of pulmonary tuberculosis by artificial pneumothorax *(ambulatory cases).*

b. That each county erect institutions (tuberculosis units) for the hospitalization of the indigent case with tuberculosis, financed by the locality and in conjunction with the medical society and charity associations. These will also furnish

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hospitalization for those patients for whom the sanatorium has little to offer (hopeless cases).

III. SPEEDY REPORTING OF ALL CASES OF TUBERCULOSIS

It should be the duty of every hospital, institution, and local physician to report the full name, age, and address of each patient under their care within twenty-four hours after the time that the patient has been diagnosed as ill with tuberculosis; special mention being made of the fact if it is a case of pulmonary tuberculosis. Notification of cases of tuberculosis has been a requirement of the State Health Department which has not been observed.

IV. FOLLOW-UP OF CONTACTS, SUSPECTS, NON-INSTITUTIONAL AND DISCHARGED CASES

The obligation of the follow-up of these cases naturally lies with the local community. We stress the decided importance of periodic examination and re-examination. You can expect to find one case of pulmonary tuberculosis in every three to four contacts. Once a positive tuberculin test is found in a child, the family should be investigated for the source of the infection.

V. REHABILITATION

Provision for the medical supervision and financial support of the patient and his family should be made by the local community until that patient is able to be fitted for some useful occupation and to resume to some degree the position of family provider. In this manner can be diminished the number of return cases. Those caring for the patient must be educated in matters relating to the disease and the home must be generally prepared to receive the patient.

VI. HEALTH EDUCATION

The public must be made tuberculosis-minded by being taught the nature and the problem of the disease, methods of control, and its prevention. Visits to the homes of the indigent by social welfare agencies and district nurses should be encouraged.

VII. MEDICAL PROGRAM

To have centers for the treatment of ambulatory pneumothorax cases requires that the general practitioner be acquainted with the indications, procedure, and complications associated with the treatment by artificial pneumothorax. The modern aspects of tuberculosis can be brought to the attention of the general practitioner by short tutorial courses, occasional talks, and periodic medical literature.

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★*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3, 306-309

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RECOMMENDATION

That x-raying of all teachers and other school employees be made compulsory before applicants are accepted for such positions. Such x-rays should be repeated at three-year intervals.

ADVANTAGES

1. Through the school program the local communities will have a lead to trace the source of the infection.

2. The State will discover patients who would ordinarily not visit the physician at the time.

3. The public will realize the need for annual medical examination.

4. The local radiologist will be the one to whom the local physicians will refer the diagnosed case for further study.

CONCLUSION

This program is sufficiently flexible to meet the individual requirements of the local communities. The school program is the only feature in which the State will take active participation. Through the school program tuberculosis can be effectively brought under control in Florida. It is believed that this program will undoubtedly prove a financial asset to the general practitioner as it will increase his practice by bringing in the families of the school children for thorough examination, in an endeavor to find the source of the infection. Any possibility of socialized medicine through this program is eliminated as the medical body is the controlling factor in its field of action.

Complete text on the above outline will be furnished on request to members of the Florida Medical Association by Doctor Arthur J. Logie, Director, Bureau of Tuberculosis, State Board of Health, Jacksonville, Florida.

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Since some mention of the National Auxiliary Letter was made in these columns, there have been inquiries as to just what it was like and some requests for samples. Your editor receives only one copy of each issue and it is not possible to send out samples, but we wish to announce that they will be on exhibit at the convention in St. Petersburg. There will be many other things on exhibit at the convention which are of interest to Auxiliary members; in fact, it is going to be a very nice convention and all good wives are urged to accompany their husbands on this little trip, to spend their time with other Auxiliary members and attend the meetings and the social courtesies which will be tenderd by the Pinellas County Auxiliary. Look elsewhere in this issue for more detailed convention plans.

The Orange County Auxiliary held its February meeting at the Perrydell in Orlando. Following luncheon, a short business meeting was held, after which members adjourned by invitation to Sorosis Club to hear a lecture by Dr. Charles Stiles of Rollins College.

The Auxiliary to the Alachua County Medical Society held an evening meeting on Feb. 19 at the home of Mrs. Edwin H. Andrews in Gainesville.

The Auxiliary to the Pinellas County Medical Society enjoyed a luncheon at the Yacht Club of St. Petersburg, Monday, Jan. 18. Mrs. F. W. Roush, president, introduced Mrs. R. J. Alexander of Waco, Texas, who is president of the Auxiliary to the medical society of her county. This group was organized in 1917 and by long experience she was able to offer many helpful suggestions. Dr. F. F. Kumm, city physician, discussed in detail the Florida state health educational program on tuberculosis. A delightful musical program was given by a trio composed



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The control of syphilis today is one of the major problems of the medical profession. The necessity for concerted action in bringing syphilitic individuals under treatment is evident from the estimate that from 5 to 10 per cent of the population is infected, and that there are more than 500,000 new infections annually.

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of Mrs. Fred Stanford, first violinist; Mr. Frank Lyon, cellist; and Mrs. A. L. Krayer, accompanist. Out-of-town guests were: Mrs. R. J. Alexander, Waco, Texas; Mrs. LeRoy Rheinberg, Chicago; Mrs. Monroe Sussman, New York City.

In each issue of the afore-mentioned News-Letter, there are special reports from the presidents of a group of states. In the January issue, our own Mrs. Harden reported for Florida and I can assure you that it was a very creditable report. Tennessee was another state reporting in this group, and I noticed that one of their projects was the sending, as a gift from the State Auxiliary, of a subscription to the National News-Letter to each president of a County Auxiliary. That is very fine to do, but it might be even better if each Auxiliary would subscribe for itself.

Those interested members who have kept up with National Auxiliary news through the pages of the A. M. A. Bulletin already know that the Bulletin has been incorporated with the Journal, but we hope that all members will now read Auxiliary news in its new form in the Journal. In an editorial, the following statement in regard to the Auxiliary was made: "The work of the Woman's Auxiliary which was formerly included in *The Bulletin,* has now assumed such proportions as to merit a special page for its activities."

Now let me quote from the message of our national president, Mrs. Fitzgerald, which appears in this same January issue of the News-Letter:

"How varied, too, have been the types of work undertaken by the states. We are proud of all of them. There is Alabama giving milk and clothing to the poor and supporting a Scholarship Fund. We find Arkansas with its Fund and with its never-ending making and giving of obstetrical kits where they are most needed. California, among many other projects, has helped raise money for a swimming pool to be used by sufferers from infantile paralysis and has also helped support an orthopedic school. Colorado, in addition to philanthropic projects adopted by the various county groups, has as a state undertaken the raising of money for a Physician's Benevolence Fund. Florida, along with its other activities, has waged a campaign to make it necessary for domestic servants to have health cards.

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In Georgia we find eager women raising money for a Student Loan Fund that has already helped nine young men complete their medical education. In addition, a compaign for Mother Welfare has given instruction on prenatal, natal, and postnatal care as well as the care itself to the poor of the white race. Indiana has held all-day health conferences for Parent-Teacher Associations. In Minnesota we find that a sale of handmade articles has earned nine hundred dollars for a tuberculosis sanitarium, and here, too, we find poor children in rural schools receiving cod liver oil through the generosity of the Auxiliary. North Carolina supports a bed in a tuberculosis sanitarium and has named it for the organizer of the State Auxiliary. Through the efforts of the Auxiliary in Oregon, the Healing Arts Amendments, which would have nullified the benefits of the Basic Science Law, were defeated. In that same state a school room for handicapped children was supported by the Auxiliary. Pennsylvania contributes most liberally to the Physicians Benevolence Fund and has for years held an all-day health conference each spring. Virginia this year took under its care the maintenance of a bed in a tuberculosis sanatorium. This bed is to be at the disposal of doctors and their dependents. In West Virginia in one year Auxiliary members made 3.378 new garments for the use of the needy, and mended many more."

And she ends her message with these words: "When your non-Auxiliary friends ask, as they so often do 'What does your Auxiliary do?' aren't you proud to be able to point to the record of achievement which this new year's inventory brings before you?"

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VOLUME XXIII
NO. 10

Jacksonville, Florida, April, 1937

Yearly Subscription, $3.00
Single Copy, 30c

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Florida Medical Association, Miami, 1938.
American Medical Association, Atlantic City, June 7-11, 1937.
Southern Medical Association, New Orleans, November 30-December 3, 1937.

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The tragedies these disorders heap upon little heads are very real tragedies. But even more serious is their possible influence on the child's future. The "laughed-at" child so often becomes the crushed and morose adolescent. And the morose adolescent frequently becomes an embittered man or woman in an unfriendly world.

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The minimum daily intake which will prevent rickets in infants is probably between 135 and 400 International units of vitamin D as supplied by cod liver oil (1). The optimum prophylactic dose is probably in the neighborhood of 1000 International units (2). It is also interesting to note that the League of Nations Technical Commission has recommended a daily intake of 340 International units of vitamin D for pregnant and lactating women (3).

Irradiated pasteurized milk containing 135 International units per quart and irradiated evaporated milk of the same potency have been found equally effective in preventing rickets in infants. The pediatrician will be interested in the following summary taken from a recent review:

> "Such evidence as is available may be interpreted to show that cod liver oil, cod liver oil concentrate milk, and irradiated milk are of equal potency for the human being, unit for unit." (1-b).

Other than the above recommendation for vitamin D intake during pregnancy and lactation (3), little definite information is available upon which to establish minimum vitamin D requirements of the human after infancy (1), yet while sunlight produces the anti-rachitic factor, most common foods are known to be deficient with respect to vitamin D (4). However, certain foods such as eggs, butter, liver and sea foods do supply this vitamin. The importance of sea foods, especially canned salmon, as carriers of vitamin D has been definitely established. A recent report on the vitamin D content of different varieties of canned salmon gave a value of 1.9 International units per gram for the least potent brand and 6 or more units per gram for several other brands (5).

From a consideration of the vitamin D values of salmon oil, the oil content of canned salmon and the quantity of canned salmon consumed annually in this country, it has been concluded that there is more vitamin D in the canned salmon sold in this country than in the cod liver oil used for both human and animal feeding (6).

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(1) a. 1937. J. Am. Med. Assn. 108, 206
b. 1936. Ibid. 106, 2150
(2) 1936. J. Am. Diet. Assn. 11, 503
(3) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.
(4) 1935. J. Am. Diet. Assn. 11, 119
(5) 1935. J. Home Econ. 27, 658
(6) 1931. Ind. Eng. Chem. 23, 1066

This is the twenty-third in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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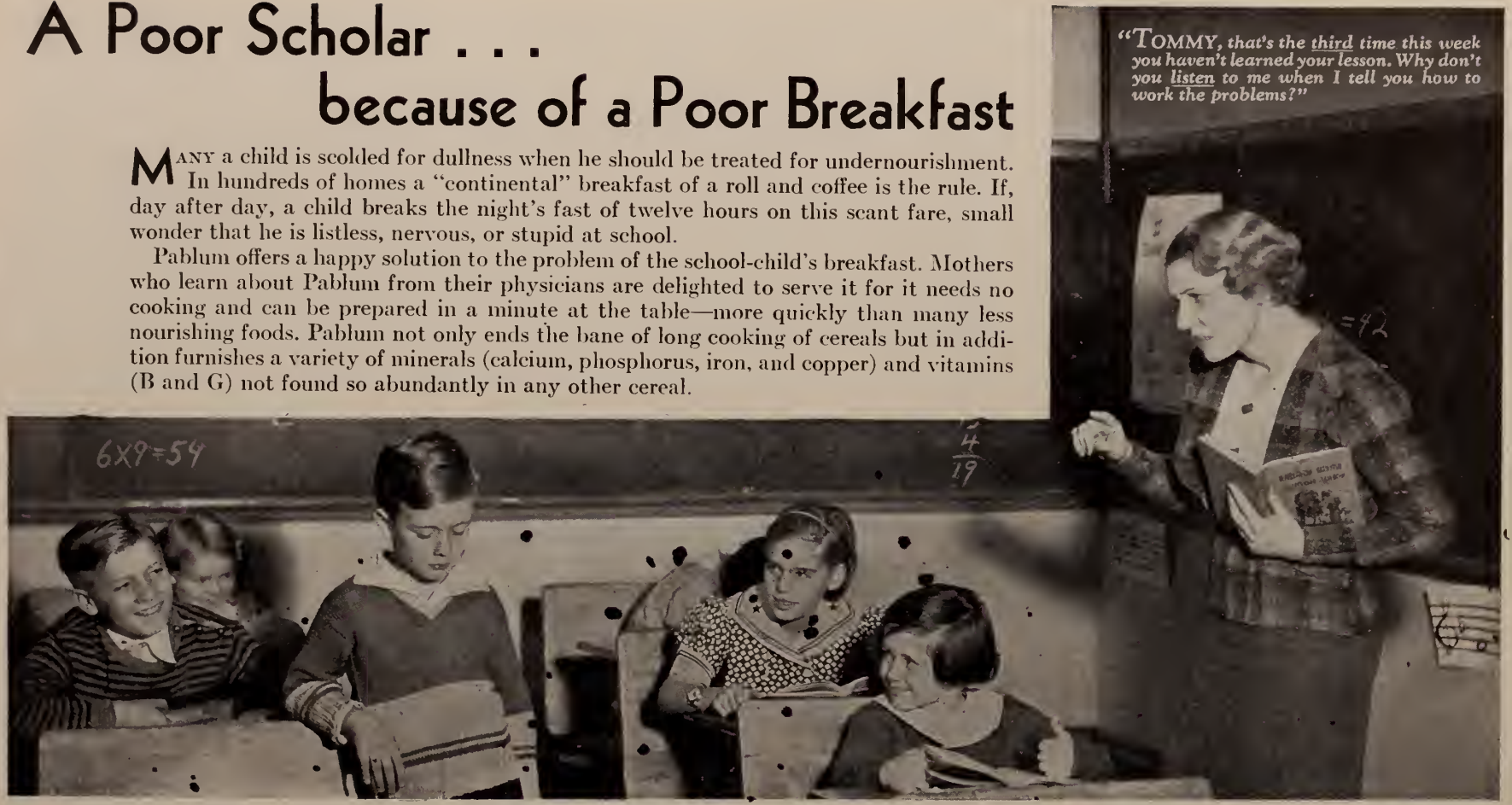
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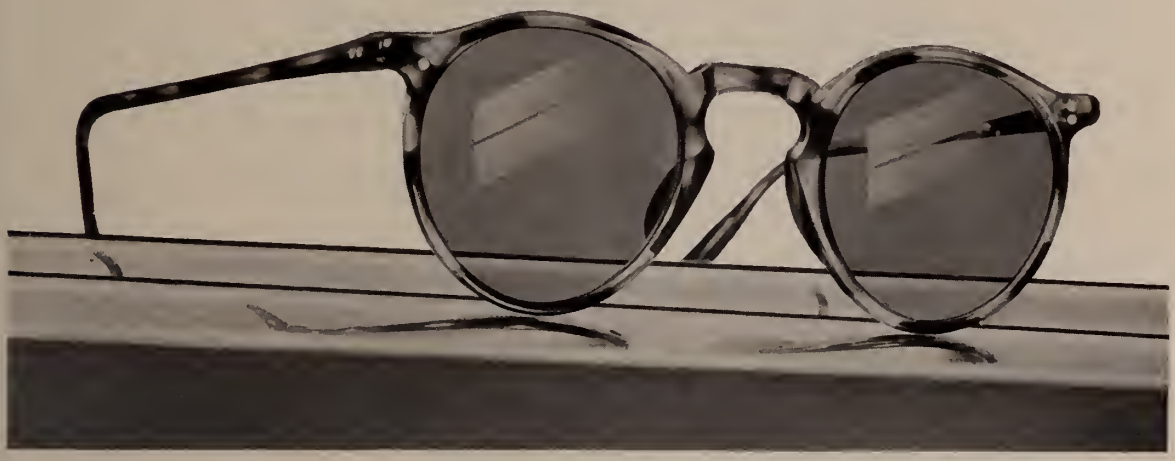
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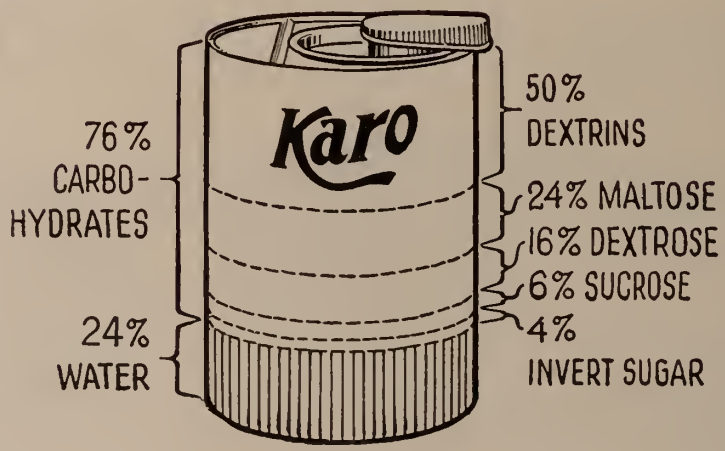
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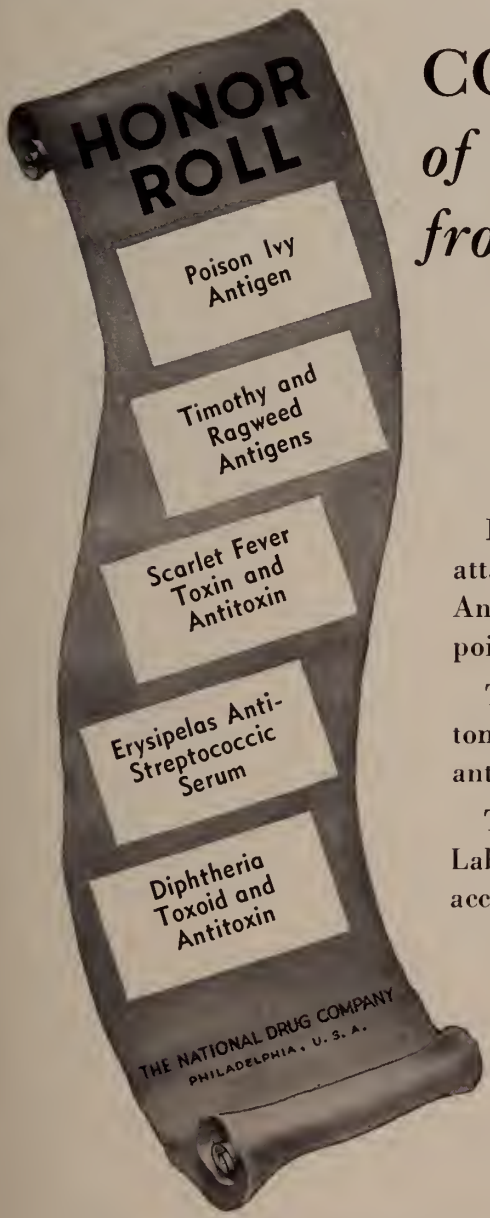
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXIII | Jacksonville, Florida, April, 1937 | Number 10

President's Address*

O. O. Feaster, M.D.,
St. Petersburg.

It has been the custom in this Association that the annual address of the President shall deal with various phases of the organization's accomplishments, and proposals for future activities rather than an essay of a scientific nature.

It is perhaps well that we have this opportunity of considering events that have taken place during the year now closing and that suggestions be presented for the consideration of those who will administer the affairs for the Association during the new year.

The plan of appointing committee members for periods of three years, with overlapping terms of service has proved to be wise. Also, the districting of the State with a representative from each district on each of the committees has been shown to be an excellent plan. Amendments to the By-Laws were offered at the House of Delegates meeting last evening to make such set-ups uniform for all committees and also to authorize and continue such new committees as were necessarily appointed during the year to care for new activities that arose.

MANAGING DIRECTOR

The need for a full time business manager has been realized for some time by many members active in the affairs of the Florida Medical Association. The accomplishments of our efficient part time manager have more than justified his position. The present very fluid and future unpredictable condition of our social state indicates the probability of the necessity for greatly increased activity on the part of the Association's headquarters. Many activities are required of busy committeemen, at considerable sacrifice of time and money, that could be and should be handled by a competent business director.

My immediate predecessor, Dr. Herbert Bryans, made the employment of a full time manager one of his major recommendations in his address at the last annual meeting. Acting upon this recommendation, the Executive Committee met in Orlando, March 21, and unanimously voted to ask the House of Delegates to accomplish this end at this time and financial and other details were worked out for their consideration. The House of Delegates last evening voted favorably on these recommendations and our capable Stewart Thompson will shortly begin his duties as full time Managing Director of the Florida Medical Association.

COMMITTEE ACTIVITIES

The officers of the Association and the members of its several committees are ever alert and tireless in their activities in the interests of all of us. Many of the members are unaware of the efforts these men are making on behalf of the general good. The past year has seen an unusual amount of safeguard afforded the private practitioner. Officers and committeemen have caused to be modified the Utopian plans of idealists with the result that private practice has not been encroached upon and definitely beneficial services have been instituted or planned for the needy. Every effort has been made to cooperate with new agencies that have come among us. Our advice and insistence has caused them to be properly directed and the doctor's economic interests have, we believe, in every instance been conserved. One cannot too highly praise the State Board of Health, Drs. Baltzell, Richardson, and Hughes and the State Health Officer, Dr. McPhaul, for their cooperation in

*Delivered before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

these protective endeavors. I am convinced that prompt and hearty cooperation with such plans with resultant supervisory control offers our greatest protection. If we refuse to cooperate with the plans offered we can confidently expect laymen to accept them and carry them out in such manner as to render them of little use to the public and probably of considerable embarrassment to the doctors. Fortunately, to date, limited finances have definitely dampened idealistic dreams and have been a protective factor. One wonders concerning the future—fears what it may force upon us—but in any event we may rest assured that our officers and committeemen will do all that is humanly possible to safeguard us. They must have our support whenever they need it.

INDUSTRIAL COUNCIL

The passage of the Workmen's Compensation Act by the last legislature initiated a new angle to the practice of medicine. Unfortunately, there is no medical representation on the Industrial Commission. With that disregard for self-protection which seems to have been typical, the Florida Medical Association, although warned of the necessity for securing representation by its Economics Committee, neglected to make the effort.

Very fortunately for the financial interests of the doctors, the Chairman of the Industrial Commission, Mr. Wendell C. Heaton, has been found to be eminently fair and cooperative. He has organized an Industrial Council composed of representatives from the various groups interested—the employees, the employers and the physicians—to whom may be appealed complaints. The committee from this Association was appointed several months ago. An amendment to the By-Laws has been proposed to give this committee official status. There have arisen numerous instances of disagreement as to fees between the physician and the insurance carriers. Whenever such occur the physician should promptly lay the facts before Mr. Heaton where fair consideration may be confidently expected and should not quietly submit to the dictation of an insurance adjustor.

HEALTH INSURANCE PLANS

There have been put into effect in various sections of the country several plans by which individuals may for small sums, frequently paid in monthly or quarterly instalments, secure hospital services in the event of illness. That such plans have considerable merit goes without saying. It is also perfectly right and proper that the hospitals enter into such arrangements, if they wish, for the sale of their services so long as they limit themselves to disposing of those services which are theirs to sell—viz: bed, board, nursing, drugs, operating and delivery room functions and the like. However, in some instances institutions have included various functions which decidedly are not theirs to contract but are definitely the practice of medicine—such as certain emergency services and the consulting services of pathologists and radiologists. In some instances the insurance contracts have later been modified to exclude phases of medical practice. Others continue them. When such arrangements are contemplated in any section of our state it behooves us to take positive and unequivocal action to prevent the inclusion of any phase of medical practice—those functions are ours and ours alone.

It has been called to the attention of this body in years past that there exists definite exploitation of doctors by a few hospitals. Physicians are employed on salaries to furnish medical services from which the institution derives a profit of several times the salary paid. Further, lay anesthetists and other lay people are employed on salaries displacing medical men and depriving them of fees which are rightly theirs.

That a hospital executive who is a physician should be one of the chief offenders is hardly to be understood. That such exploitation can only exist because of the toleration of the other physicians is not refutable. That institutions profiting from the sale of the services of the present exploited group should turn to the other fields of practice should be expected and it would seem that surgeons, internists, urologists, dermatologists, ophthalmologists, gynecologists and obstetricians cannot, with very good grace, resent the entrance into their respective domains when they have failed to rally to the defense of their brother practitioners. One wonders why such hospitals should hesitate.

POLITICS AND LEGISLATION

The physicians of Florida have been, until perhaps recently, quite indifferent in the exercise

of an influence in politics which has been theirs potentially. As a result of this attitude much legislation of a medical nature unfavorable to our interests and to the welfare of the public has been put on the statute books, in all probability to remain. Further, this indifference of the past has given legislators and government officials, city, county and state, the idea that our wishes need not be seriously heeded for no threat of concerted adverse voting strength is to be feared by ignoring us.

The economic awakening that has been ours during the past few strenuous years is beginning to be recognized but until we take a militant, active and unified stand for our needs we will continue to make a rather poor showing.

The Legislative Committee of this Association, so ably headed by Julius C. Davis of Quincy, is fighting an uphill battle at the present time because of the lack of adequate support from each and every one of us. They are endeavoring to have enacted several bills of inestimable importance to the members of the Florida Medical Association. More preliminary work has been done this year than ever before. It is probable that with wholehearted support from the membership in bringing influence to bear that three of these bills will have a very fair chance of being enacted. A fourth, the basic science law, is being fought vigorously by at least one of the cults. Such a law is vital to future standards of healing practices. The cults will never be legislated out. A proper basic science law will insure that cultists acquiring a legal right to treat the sick will be of more than sixth grade schooling and that their legal right to engage in parctice does not come through purchase. The entrance of the untrained and unschooled will be materially reduced which, with the inevitable assistance of the Grim Reaper, will constantly and progressively improve the breed. Let us exert ourselves not merely in our own defense but to live up to the traditional responsibility which is ours by right of heritage, if none other—the protection of the sick.

Our conduct in the use of our influence with regard to appointive medical and related positions is open to definite criticism. Individuals or small groups, without regard to the general wishes of the profession, exert themselves to have this or that friend given a job. Usually there are several such individuals or small groups urging as many candidates. The result is confusion—for the Governor or other appointing official immediately realizes that the Florida Medical Association is not definitely, unifiedly and aggressively asserting itself. An endeavor has been made this year to have all such suggestions reach the Governor through the Executive Committee as the definite wish of the Association. Unfortunately, some of us, although knowing the rules, have not played the game and we make little headway. This organization must adopt some definite plan of procedure and insist that the plan be respected. It is believed that the Executive Committee, which alone by our constitution has authority to act when this body is not in convention, is the logical unit to sift recommendations and pass them on. Let us subjugate petty and selfish interests and act for the good of the majority. Your incoming president, your executive and other committees will be ever alert and constantly informed. Let us help them rather than obstruct their efforts.

BIRTH CONTROL

Many of the laity as well as the doctors look upon birth control as an important health measure. It is a question that is becoming of rather definite importance and because of that is being forced upon the attention of physicians. The medical profession must assume responsibility for proper guidance. The United States Circuit Court of Appeals on January 29, announced that physicians may give birth control information for the purpose of promoting the well-being of their patients.

Commenting on this decision the World Telegram said editorially: "With that decision in the bag and with questions of legality swept away, we can turn now to the medical profession generally and to our public health services specifically and ask them how soon they are going to provide necessary clinics and services 'to promote the well-being' of the child-bearing women of the country. Surely the old-line doctors will not let the judges leave them in the lurch in the march of progress."

It is recommended that the Committee on Maternal Welfare give attention to this question and make recommendations at the next annual meeting for the Association's consideration.

OUR JOURNAL

The Association at considerable monetary outlay and great imposition on several of its altru-

istic members publishes the Journal of the Florida Medical Association. Those who read this periodical feel that it is a most creditable organ for an organization of this size. It has been repeatedly brought to the speaker's attention that matters of considerable importance printed in the Journal were overlooked because the Journal was not read. From a scientific standpoint the Journal can be only as good as the material submitted for publication. That we have in the State the intelligence and the talent to constantly improve the quality of the organ goes without saying; that the Editor and the Editorial Board who give unstintingly of their time and brains, gratis, are shown very poor cooperative support is also true. Let us read the Journal—let us support it.

DEFENSE AGAINST MALPRACTICE SUITS

There have occurred several instances to illustrate a definite need for increased protection against malpractice suits—not financial protection but aggressive defense for the protection of our reputations.

While the majority of the members, no doubt, are covered by the State Association's blanket policy or other agencies which guarantee that judgments or compromise settlements, within specified limits, will not have to be paid by the doctor involved, it remains a fact that compromise settlements are made unnecessarily and are an admission of the guilt charged. The insuror shows evidence of desiring to effect a compromise because of financial expediency rather than go to the trouble and probably greater financial outlay of defending a suit, however baseless the grounds upon which it is brought.

It is recommended that this Association take cognizance of the growing number of suits against its members for alleged malpractice; that it recognize that the present manner of handling these cases deprives the members of that protection most needed—defense of their reputations, which are definite secondary considerations to the insurors; that the increased cost of medical protective insurance is definite admission of the unsatisfactory manner of handling these claims; that the increased cost as the result of unsatisfactory defense is passed directly to the members of this Association so that the insuror may, naturally, continue to operate at a profit. It is urged that the State Association undertake to defend any and all members with adequate and competent legal counsel, acting in cooperation with a Legal Advisory Committee of this Association, to insure proper defense of the reputations of its members, primarily. Secondarily, this will discourage suits and will tend to reduce, as a result, the cost of medical liability insurance. Such a plan is in force in several state medical organizations. Information from our sister state, Georgia, is to the effect that "such an arrangement has been unusually successful. Our medical defense costs our Association annually from $1,400 to $2,000." This in an Association whose membership is 50 or 60 per cent greater than ours. The recent increases in the cost of medical protective insurance exceeds the probable costs of such activity by the Association and it is predicted that this cost will again advance; consequently, were an increase of approximately one to two dollars in dues made for the specific purpose of defense we would effect a financial saving, to say nothing of a saving in reputations and an abatement of a growing nuisance.

The Legal Advisory Committee suggested should be composed of particularly qualified members whose advice would be available to the attorney in preparing defense and who would be present for further advice or testimony in the event of actual court procedure.

Before closing these remarks, I wish to make reference to the activities of the Medical Post-Graduate Course Committee through whose efforts there have been carried on successfully four post-graduate courses at which outstanding teachers have given lectures of very high character. Doctor Cason, the Chairman of the Committee, assisted by Doctor Tillman and others, are due great credit for their accomplishments and are entitled to far greater support than they have had. The total cost to the Florida Medical Association of these four weekly post-graduate courses has been approximately $65.00. An innovation this year takes the assembly from Gainesville to Orlando where it is hoped the attendance which has averaged about one hundred a year in the past, will be greatly increased.

I wish to take this opportunity of expressing sincere thanks to the other officers of the Association, to Dr. Stewart Thompson and the staff of his business office, and to various committeemen and members generally who have accorded me such wonderful cooperative support and many courtesies during the past year.

PROCEEDINGS

of the

SIXTY-FOURTH ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

HELD AT ST. PETERSBURG, FLORIDA

APRIL 5, 6 and 7, 1937

FIRST GENERAL SESSION

The Sixty-fourth Annual Meeting of the Florida Medical Association was called to order at 1:30 p. m. Monday, April 5, in the Ball Room of the Vinoy Park Hotel, St. Petersburg, by President O. O. Feaster.

The Honorable J. A. Smith, Mayor of St. Petersburg, gave the address of welcome.

Dr. Norval M. Marr, President of the Pinellas County Medical Society, also delivered an address of welcome.

President Feaster introduced Dr. Arthur G. Fort of Atlanta, delegate from Georgia.

Dr. Fort: "I need no reason to come to Florida; all I need is an excuse. I love to come. It is a great pleasure. The Medical Association of Georgia sends you her greetings. We meet in Macon the 14th of next month and would like to have as many of you as can join us there."

President Feaster then introduced Dr. W. S. Cook, of Albany, delegate from Georgia.

Dr. Cook: "I feel honored and I am happy to be here. I hope I have the pleasure of coming again. Thank you."

The President then read the following telegram: "The Medical Association of Georgia sends greetings to the Florida Medical Association and wish for our good neighbors much success at their sixty-fourth annual session. Dr. Arthur Fort and Dr. W. S. Cook will attend your meeting."

President Feaster read the following telegram from George R. Taylor, President, Florida State Pharmaceutical Association: "The Florida State Pharmaceutical Association extends its heartiest greetings to you on your sixty-fourth annual convention of your society. At this time we feel sure your accomplishments will be many and far-reached. I wish to assure you that our legislative committee, Mr. A. W. Martin, Chairman, of Miami, and our secretary-manager, Mr. W. T. Dunn of Tampa, will work with your legislative committee 100%. We feel that our professions are somewhat allied. I am sure we will be very successful in enacting some good public health measures for the benefit of our peoples at the present session of our state governing bodies in Tallahassee. Fraternally."

There being no further business, the meeting adjourned.

FIRST SCIENTIFIC ASSEMBLY

The Scientific Assembly convened at 2:30 p. m., Monday, April 5, in the Ball Room of the Vinoy Park Hotel, with Dr. Leigh F. Robinson presiding.

The following papers were read and discussed:

1. "Some Observations on Blood Pressure," Dr. J. G. Gainey, Blountstown.
2. "Trichinosis," Dr. T. F. Hahn, DeLand.
3. "The Diagnosis of Coronary Heart Disease," Dr. William C. Blake, Tampa.
4. "Heart Block," Dr. T. Z. Cason, Jacksonville.
5. "Treatment of Tetanus," Dr. Joseph S. Stewart, Miami.
6. "Syphilis," Dr. Henry E. Palmer, Tallahassee.

MEETING OF THE HOUSE OF DELEGATES FIRST SESSION

The House of Delegates convened at 7:00 p. m. Monday, April 5, in the East End of the Ball Room of the Vinoy Park Hotel.

The meeting was called to order by the President, Dr. O. O. Feaster.

The following delegates were seated:

DELEGATES

Alachua County Medical Society:
J. E. Maines, Jr.

Bay County Medical Society:
W. C. Roberts

Brevard County Medical Society:
T. C. Kenaston

Broward County Medical Society:
Leigh F. Robinson

Columbia County Medical Society:
L. M. Anderson

Dade County Medical Society:
M. J. Flipse
Homer Pearson
R. N. Burch
J. E. Hall
Edgar Peters
H. A. Walker
Joseph Stewart
E. N. McKenzie
Roy J. Holmes
W. W. McKibben

Duval County Medical Society:
L. Y. Dyrenforth
Edward Jelks
Ferdinand Richards
E. T. Sellers
Kenneth A. Morris
C. D. Rollins

Escambia County Medical Society:
J. M. Hoffman
H. L. Bryans

Hillsborough County Medical Society:
J. C. Dickinson
J. R. Boling
George L. Cook
W. M. Rowlett
W. C. Blake

Lake County Medical Society:
LeRoy Oetjen

Lee County Medical Society:
H. J. Stipe

Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society:
J. C. Robertson
B. A. Wilkinson

Manatee County Medical Society:
H. Gates

Marion County Medical Society:
R. D. Ferguson

Orange County Medical Society:
W. H. Spiers
J. S. McEwan
H. A. Day

Palm Beach County Medical Society:
F. K. Herpel
W. L. Shackelford
W. O. Arnold

Pinellas County Medical Society:
W. C. McConnell
C. A. Williams
A. J. Wood
W. M. Davis

Polk County Medical Society:
R. L. Cline

St. Johns County Medical Society:
Reddin Britt

St. Lucie-Okeechobee-Indian River-Martin County Medical Society:
A. M. Sample

Seminole County Medical Society:
J. W. Martin

Sumter County Medical Society:
W. E. Mitchell

Taylor County Medical Society:
C. A. O'Quinn

Volusia County Medical Society:
J. Ralston Wells
L. B. Bouchelle

DeSoto-Hardee-Highlands, Jackson, Madison, Monroe, Pasco-Hernando-Citrus, Putnam, Sarasota and Walton-Okaloosa County Medical Societies were not represented.

The first order of business was the adoption of the minutes of last year's meeting. It was moved by Dr. J. M. Hoffman and seconded by Dr. L. F. Robinson that the minutes be adopted as published in the May, 1936, Journal. Voted and carried.

President Feaster called for the nomination of one delegate and one alternate to the House of Delegates of the American Medical Association for two-year terms.

Dr. Homer Pearson was nominated by Dr. W. C. Roberts as a delegate to the A. M. A. for a two-year term, and the nomination duly seconded.

Dr. Meredith Mallory was then nominated by Dr. H. A. Day to succeed himself as a delegate to the A. M. A. for two years. Nomination seconded.

On motion by Dr. J. M. Hoffman, seconded by Dr. J. E. Maines, and carried, the nominations were closed.

A roll-call vote by secret ballot was requested. Drs. George L. Cook, M. J. Flipse and J. S. Turberville were named tellers.

Dr. Mallory received the majority of the votes cast and was then declared re-elected a delegate to the A. M. A. for a period of two years.

A motion by Dr. J. S. McEwan that the defeated candidate be declared the alternate was ruled out of order by the Chair. Dr. Joseph S. Stewart appealed from the decision of the Chair. The motion was lost on standing vote and the ruling of the Chair sustained.

President Feaster then called for nominations

for an alternate to the A. M. A. for a two-year term.

Dr. C. D. Christ was nominated by Dr. J. E. Hall. Nomination seconded.

Dr. Homer Pearson was nominated by Dr. Roy J. Holmes. Nomination seconded.

Dr. M. J. Flipse was nominated by Dr. Edgar Peters. Nomination seconded.

On motion by Dr. R. D. Ferguson, seconded by Dr. J. E. Maines and Dr. L. M. Anderson, and carried, the nominations were closed.

Dr. Flipse requested his name be withdrawn from the nominations but Dr. Peters insisted on his name standing.

Dr. J. Ralston Wells took Dr. Flipse's place as teller and ballots were taken.

Dr. Homer Pearson received the majority of the votes cast and was declared alternate to the A. M. A. for a two-year term.

The following proposed amendments to the Constitution which were read at the meeting in April, 1936, and copies of which had been mailed to all secretaries of county medical societies sixty days prior to the meeting now in session, were read by Doctor Richardson, the secretary:

Article XI shall be amended to read as follows: "Any article of the Constitution may be amended by two-thirds vote of the Delegates registered at that Annual Meeting and referred to the component county societies for ratification during the ensuing year; each society ratifying by majority vote of its members present at any regular meeting; it being necessary for three-fourths of the component societies to vote in favor of its ratification during the year."

Section 3, Article VII of the Constitution relative to election of officers, shall be amended to read as follows: "The officers of this Association shall be elected by the House of Delegates at its last regular session of the Annual Meeting, and referred to the last General Session for confirmation; and any member shall be eligible to any office named in Section 1 of Article VII of the Constitution, but no person shall be elected to such an office who is not in attendance during the Annual Meeting (except the Secretary, Treasurer, and the Editor of the Journal) and who has not been a member of the Association for five years." (Amendment to Sec. 3, Article VII reconsidered at second session Tuesday and lost.)

Dr. H. A. Day moved the adoption of the amendments; Dr. L .F. Robinson seconded the motion. Motion prevailed.

Dr. L. M. Anderson presented the following resolution (read by Dr. J. E. Maines):

"Resolved, That no member of the Florida Medical Association shall sign any political paper or letter with his title as a member of this Association, or use the stationery of this Association for said purposes. This is not intended to keep any member from being active politically."

On motion by Dr. R. D. Ferguson, seconded by Dr. H. A. Walker, and carried, the resolution was adopted as read.

Dr. E. T. Sellers read the following resolution regarding the employment of a full-time Managing Director:

"*Whereas,* the work of this Association is now such as to warrant the employment of a regular Managing Director, to assist the officers and to build up and increase interest in the County Societies; and

"*Whereas,* this House of Delegates is in favor of employing, on behalf of the Association, a person competent to perform the said work; and

"*Whereas,* the Executive Committee has considered the subject and recommended this resolution and that Stewart G. Thompson, of Jacksonville, Florida, be employed to fill said position, for a period of five years and thereafter, from year to year, until due notice of termination of the employment be served by the Association or by Dr. Thompson, one upon the other; such employment to carry with it a minimum salary of Six Thousand ($6,000.00) Dollars per annum, payable in twelve equal monthly instalments, and also an expense account to cover the necessary traveling and other expenses of said Managing Director, in such amount as may from time to time be authorized or approved by the Executive Committee;

"Now, Therefore, Be It Resolved: That the foregoing plan and recommendation of the Executive Committee be and the same are hereby in all respects approved and that the Association officers, to-wit, the President, the Chairman of the Executive Committee and the Secretary, be and they are hereby authorized, empowered and directed to forthwith negotiate and make and execute with Dr. Thompson an agreement, in writing, employing him to fill said position with this Association, for the period and upon the terms hereinabove mentioned, with such specification of further details as may be agreed upon and approved by said officers and incorporated in said contract, and that said agreement, when so reduced to writing and executed for the Association and by Dr. Thompson shall be and constitute a valid and binding obligation of this Association."

Dr. W. H. Spiers moved the adoption of the resolution. Motion seconded by Dr. L. M. Anderson. Dr. M. J. Flipse endorsed the resolution. The motion prevailed. Dr. Feaster expressed his gratification at the action. Dr. M. J. Flipse moved that the vote be declared unanimous; seconded and carried.

Dr. Edward Jelks read the following resolution:

"*Whereas,* it has been brought to the attention of the Florida Medical Association that certain institutions in the State have been securing the services of practitioners not in sympathy with the standards of this Association, for purposes of instructing certain groups; and

"*Whereas,* certain institutions in the State, in organizing their staffs for caring for the sick, have availed themselves of the services of practitioners who are not members of the Florida Medical Association;

"Therefore, Be It Resolved, that this body go on record as being opposed to the appearance of its members on staffs or programs giving courses of instruction

in medical subjects, diagnosis of disease, and care of the sick, in association with the above mentioned practitioners." (*See page 525 for resolution adopted*).

Dr. Jelks discussed the purpose for which the resolution was introduced. Dr. L. M. Anderson moved its adoption. Dr. M. J. Flipse expressed his belief that the wording of the resolution would prevent the members of the staff of the Jackson Memorial Hospital in Miami from retaining their membership on the staff with a full-time pathologist who has not been elected to membership in the Dade County Medical Society at this time and proposed the following amendment:

In the second paragraph, strike out the words, "who are not members of the Florida Medical Association" and insert in lieu thereof, "who are not in sympathy with the aims and objectives of the Florida Medical Association."

Dr. R. L. Cline seconded the amendment. After much discussion, a vote was taken and the amendment lost.

Dr. Edward Jelks proposed the following amendment to the second paragraph:

Strike out the words, "who are not members of the Florida Medical Association" and insert in lieu thereof, the words, "who are not members of the Florida Medical Association or the allied professions."

Dr. Reddin Britt proposed as an amendment to the amendment that the local county society be allowed to determine the status of practitioners and have them answerable to the county medical society.

Further discussion brought up a new motion by Dr. R. L. Cline that the resolution be referred back to the original committee and let them get together in a group and thresh this out for presentation later; the committee to report back at the next session of the House of Delegates. Dr. W. C. Roberts seconded the substitute motion and it was duly carried and the resolution referred back to the committee for revision.

Dr. W. M. Davis read the following resolution on compulsory health examinations:

"*Whereas,* it has been brought to the attention of the Executive Committee of the Florida Medical Association that there are several communities or large cities in the state in which compulsory health examinations are required in cases of food handlers, barbers, and other employees, and that such examinations are not recognized by city health authorities if made by members of the component medical societies other than those employed by the health departments; and

"*Whereas,* many applicants for this examination are fully able and willing to pay the physician of their choice, but heretofore it has been the policy of the city health officers in these cases to recognize only examinations made by employees of their own departments for which a stipulated fee is paid to the health department; and

"*Whereas,* your committee feels that this constitutes a definite encroachment upon the practice of medicine and that in just as many cases as otherwise the applicant would receive a more thorough examination at the hands of a private physician, and also that any group of men capable of caring for the indigent patients of a city or community in the matters of major operations and serious illnesses may well be trusted with the routine health examinations in the cases of all applicants able and willing to pay for such examinations;

"THEREFORE, BE IT RESOLVED, that the Florida Medical Association go on record as being opposed to this practice and affirm its belief that any examination made by a member of its component societies should be accepted by health authorities."

On motion by Dr. R. D. Ferguson, seconded by Dr. W. H. Spiers, and duly carried, the resolution was adopted as read.

The following report of the Council was read by Dr. W. McL. Shaw, Chairman:

REPORT OF COUNCIL

To the President and Members of the House of Delegates, in Session at St. Petersburg, Florida:

At the pre-convention meeting, held in Jacksonville, January 17, 1937, the district councilors' reports were received. These reports were published in full in the February number of the Association's Journal. As chairman of the Council, I will make a brief outline of some of the more important accomplishments, as given in these reports.

As mentioned in the Journal, 1936 was the record year of our Association, in that it represents the largest number of paid up memberships in the history of the Association. There were 1,126 members who paid State Association dues for the year. The previous record was held by the boom year, 1927, with 1,106 paid up memberships. The credit for this splendid showing goes to the component societies and their respective treasurers. During the year, twenty-eight of our thirty-two component societies had a one hundred per cent record of paid members. When one stops to realize that only four societies from the entire state failed to collect one hundred per cent of their dues, the record is indeed encouraging. This united strength of active component societies creates a powerful State Association.

The councilor of the first district reports that

an organization was fostered for a political health council composed of doctors, dentists, nurses, and druggists. A maternal and child hygiene clinic was established in the north end of Escambia County, by permission of the local society. A Gulf Coast Clinical Society was organized which is to meet at such dates as will not interfere with, or detract from, the meetings of the respective state associations. A committee from this district met with committees from Mobile, Alabama, and Gulfport, Mississippi, to perfect this new medical organization. The Washington-Holmes County Medical Society was reorganized with nine members and their request for a charter will be received at this meeting.

The fifth district reported among the guest speakers at the societies in the district, Dr. Arnold Bargen of the Mayo Clinic and Dr. William Allen Pusey of Chicago.

In the sixth district resolutions were passed in one of the societies to require members to secure affidavits from all criminal abortion patients, stating who induced the abortion, before assuming any responsibility in the case.

In the seventh district guest speakers were reported as Doctors Julian A. Moore and A. B. Craddock of Asheville, North Carolina, Dr. J. A. Bargen of the Mayo Clinic, and Dr. William E. Lower of the Cleveland Clinic, and also Dr. H. Hamilton Cooke of Miami. A banquet was given to Dr. James S. McLester, President of the American Medical Association.

Your councilor from the eleventh district reports that a notorious naturopath, who has repeatedly and flagrantly infringed on the legitimate practice of medicine on the strength of a fraudulently obtained diploma from a quasi-medical institution, has finally left Palm Beach County for parts unknown. His nefarious activities over a period of almost ten years left little to the imagination. A more rigid interpretation of the medical practice act seems mandatory if such experiences are not to be repeated throughout the state.

The keynote of the councilors' reports was that harmony prevailed during the past year. Every effort had been made to bring into the membership of the local societies all doctors who were practicing and eligible for membership. Each councilor made an effort to visit all county societies in his district, and the officers of the Association very graciously accepted invitations from many of the societies, as guest speakers.

Action at the last meeting of the House of Delegates changed the number of councilor districts from twenty-one to twelve. In our opinion, twelve councilor districts will produce better results than a larger number. Each councilor district comprises two committee districts and the set-up in this way is very uniform; and one councilor can, very easily, look after the interests of one-twelfth of the state.

I wish to take this opportunity of expressing my appreciation for the loyalty of the councilors, who have served the interests of the Association in their districts so acceptably.

Respectfully submitted,

W. McL. Shaw, Chairman.

It was moved, seconded and carried that Dr. Shaw's report be adopted.

Dr. L. F. Robinson read the following proposed amendments to the By-Laws:

Chapter VII of the By-Laws shall be amended as follows:

The first paragraph of Section 1 shall read: Regular committees shall be the Executive Committee (or may be called the Board of Governors) (Section 2); a Committee on Scientific Work (Section 3); a Committee on Legislation and Public Policy (Section 4); a Committee on Publication (Section 5); a Committee on Medical Education and Hospitals (Section 6); a Committee on Public Relations (Section 7); a Committee on Necrology (Section 8); a Committee on Medical Post-Graduate Course (Section 9); a Committee on Cancer Control (Section 10); a Committee on Medical Economics (Section 11); an Inter-relationship Committee (to work with similar committees from allied professions—dentists, druggists and nurses) (Section 12); a Committee on Tuberculosis and Public Health (Section 13); a Committee on State Controlled Medical Institutions (Florida State Hospital and Florida Farm Colony) (Section 14); a Committee on Maternal Welfare (Section 15); a Committee on Child Health (Section 16); an Advisory Committee to the Woman's Auxiliary (Section 17); a Committee as Representatives to the Industrial Council (Section 18); a Committee on Venereal Disease Control (Section 19). They shall be appointed by the President as hereinafter prescribed. The Committee on Arrangements shall consist of the component society where the annual meeting of the Association is to be held (Section 20).

The Section numbers of Chapter VII shall be changed as follows: Section 6 shall be 20; Section 7 shall be 6; Section 8 shall be 7; Section 9 shall be 8; Section 10 shall be 9; Section 11 shall be 10; Section 12 shall be 11; Section 13 shall be 12; Section 14 shall be 13; Section 15 shall be 14; Section 16 shall be 15.

Section 15 shall be amended to include this clause: This Committee shall hold joint meetings with the Committee on Child Health and the two, jointly, shall function as the Committee on Maternal Welfare and Child Health. The chairman of this committee shall be chairman of the joint committee. Section 16 shall provide for a Committee on Child Health: The Committee on Child Health shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year,

two for two years and two for three years, and thereafter they shall be appointed for three years, as the terms expire. The chairman of this committee shall be appointed by the President. The duties of this committee shall be such as usually fall upon such a committee. This committee shall hold joint meetings with the Committee on Maternal Welfare, and the two, jointly, shall function as the Committee on Maternal Welfare and Child Health. The chairman of the Maternal Welfare Committee shall be chairman of the joint Committee.

Section 18 shall be added to include a Committee as Representatives to the Industrial Council: The Committee as Representatives to the Industrial Council shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years and two for three years and thereafter they shall be appointed for three years, as the terms expire. The chairman of this Committee shall be selected by the President. The duties of this Committee shall be to represent the Florida Medical Association at meetings of the Industrial Council.

Section 19 shall be added to include the Committee on Venereal Disease Control: This Committee shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years and two for three years and thereafter they shall be appointed for three years as the terms expire. The chairman of this Committee shall be selected by the President. The duties of this Committee shall be such as usually fall upon such a committee.

The number of the Section pertaining to reports of committees to the House of Delegates shall be changed from 18 to 21.

Sections 2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 17 of Chapter VII of the By-Laws shall be amended by deleting the clause, "This Committee shall meet immediately after the adjournment of the annual meeting and elect its chairman," and inserting in lieu thereof, "The President shall select the chairman of this Committee."

Section 2 of Chapter VII of the By-Laws shall be amended to include the following addition: Invitations for the next annual meeting of the Florida Medical Association shall be presented to the Executive Committee (or Board of Governors) prior to or at the pre-convention meeting. This Committee shall investigate the facilities for entertaining the Association and the feasibility of holding the annual meeting in such places, and recommend the place most desirable, at that time, to the House of Delegates at its first regular meeting, for approval. In the event there is no invitation, the Executive Committee shall recommend the place most desirable.

Section 15 of Chapter III shall be amended to include the following addition: Upon recommendation of the Executive Committee.

The second paragraph of Section 1, Chapter VI of the By-Laws shall be amended by deleting the clause, "The councilors shall meet immediately after the adjournment of the annual meeting and elect their chairman and a secretary and the latter shall keep a record of the proceedings" and inserting in lieu thereof, "The President shall select the chairman of the Council."

Dr. W. H. Spiers: "I wish to endorse these amendments to the By-Laws tonight and you can look them over and tomorrow discuss them if necessary."

Proposed amendments to be brought up for consideration at the second session of the House of Delegates on Tuesday, April 6.

Dr. Herbert L. Bryans presented a group of charts showing the relationship of the committees of the Florida Medical Association one to the other for the consideration of the Association. Dr. Feaster expressed the appreciation of the members for showing and explaining the charts. Dr. W. H. Spiers moved that these charts be referred to the Executive Committee for consideration and presentation next year. The motion was seconded by Dr. L. M. Anderson and duly carried.

The report of the Committee on Legislation and Public Policy was read by Dr. J. C. Davis, as follows:

REPORT OF THE COMMITTEE ON LEGISLATION AND PUBLIC POLICY

In June, 1936, the members of our committee met in Gainesville, during post-graduate week, and, at that time, we discussed needed medical legislation. We rehashed and revamped the bills we had attempted to get by in 1935. These bills were simplified and two or more objectives were incorporated in one bill. We also eliminated a bill or two which created the upset of the whole Public Health Committee in the house at the last session.

As it stands today, we have two medical bills: The Lien Law and the Basic Science Bill, and there is no use of my going into detail about these bills, when every member has been furnished a copy of our little booklet, "Why Does Florida Need a Basic Science Law and Improved Medical Practice Act?" I had one physician write and thank me for the little booklet and then asked me what I thought about getting up a basic science law.

I trust that the various District and County Medical Societies have contacted their legislators and impressed them sufficiently to convince them of the need of improved medical legislation. Your Chairman met with a group of legislators at Pensacola and the various legislative committees. At this meeting, we all had a round table discussion of our bills and it was very apparent that few of these legislators had read our little booklet, but they all had read the letter and pamphlet issued by the Chiropractors opposing the Basic Science Law. After going into these bills in detail, we left the meeting with the im-

pression that we had "sold ourselves" and overcome the objections voiced by our opponents.

I cannot impress upon you too strongly the necessity and the urgent need of a whole-time man to look after our interests in Tallahassee during the next six weeks or two months and I do not know of a better man to do this than our efficient Business Manager, Dr. Stewart G. Thompson. I also suggest that the two medical bills and the Lien Law be introduced in the Senate as public health committee bills, provided that this can be done, and I believe that it can be. I recommend that these bills be expedited through the Senate as rapidly as possible and then sent to the House as Senate Bills. By them being both Senate and Committee Bills, they will come nearer receiving preferred listing on the calendar. After disposing of these bills, then I recommend introducing the Basic Science Bill, where we will expect a fight.

The Pharmaceutical Association has two bills that we wish to endorse—one of them with reference to the sale of barbituric acid preparations without a physician's prescription and the other to stop the promiscuous sale of various so-called contraceptives. These are excellent bills and should have our support. The Dental Association also wishes to cooperate with us.

The Osteopathic physicians and surgeons cooperated with us in 1935 and also several years ago when we attempted to pass the Basic Science Law. This year, they have not voiced any opposition and I believe they will be with us.

I do not believe it is necessary to make any further report other than to urge each of you men, when you return home, to keep in close touch with your Senators and Representatives and insist upon their seeing that the bills reported out of the Public Health Committee get proper consideration before the legislative body.

Respectfully submitted,

J. C. Davis, Chairman;
Horace A. Day,
Henry C. Dozier,
Walter C. Jones,
Whitman C. McConnell,
Frederick J. Waas.

On motion made by Dr. L. F. Robinson, seconded by Dr. Homer Pearson and carried, the report of the Committee on Legislation and Public Policy was adopted.

Dr. Walter C. Jones, Jr., Chairman of the Committee on Publication, made the following report:

REPORT OF COMMITTEE ON PUBLICATION

We have been more or less a silent committee although we have been functioning regularly and it is necessary that we carry on our work in order that the Journal may receive the proper material for publication. We are trying to become a little more strict in looking over the papers and don't feel hard towards us if your paper is referred back to you for study. I think many of the mistakes made have been due to lack of time devoted to your papers. I assure you that your committee wants good material but it is impossible for the Publication Committee to edit papers for publication unless they are properly prepared. We insist that your papers come to us on original copies. I would like to impress on you these two points and say that we are trying to keep the standard of your Journal as high as possible and to urge that you submit all articles read before local county societies in order that we may have more material from which to select for publication in the Journal.

On motion made, seconded and carried, the report of the Committee on Publication was accepted.

The report of the Committee on Public Relations was read by Dr. J. Ralston Wells, as follows:

REPORT OF PUBLIC RELATIONS COMMITTEE

Your Committee this year has confined itself, through force of circumstances, to radio broadcasting. The broadcasting has been done through the courtesy of WRUF, and our program is on the air every Sunday evening at six o'clock for a fifteen-minute period. With few exceptions, the speakers have been very cooperative in personally appearing to deliver their addresses. Results are hard to determine, but Director Garland Powell assures me that he feels the educational program is well worth while, and is a cog in a great machine to slowly educate the public along ethical medical lines.

During the year there have been several inquiries concerning unethical practitioners, and these have been referred to proper departments in the Association. The term Public Relations implies a liaison between the Florida Medical Association and the laity, and the members of

your Committee, being strategically placed as they are, feel that this Committee could be utilized much more than it is. For instance, reports concerning unethical practitioners and quack propaganda could be assembled. The dissimination of medical knowledge to lay organizations through our speakers' bureau is not functioning because of lack of requests to do so, but should be utilized.

Your Committee members this year have each had his full share in the amount of work put on by the Committee, and each one has dispatched it with credit. I wish personally to thank each member of the Committee for his cooperation one with the other.

Your Committee feels that a letter of appreciation from this Association should be sent to Director Garland Powell and his assistants in WRUF for not only his aid in making the broadcasts possible, but also for the extreme degree of cooperation in reading manuscripts for the speakers when delayed at the last moment, and for the courtesy in making each speaker feel at ease when in the station.

Suggestion: At the discretion of this annual meeting, your Committee feels that it could be of vastly more importance to the Association and to the public of Florida if certain matters, as aforementioned in this report, in the nature of liaison could be referred to the Committee for proper placement and action, some to the Executive Committee, some to the Committee on Legislation, some to the State Board of Health, some to the State Board of Medical Licensure, and some to itself. If this meeting might designate some such procedure, we feel sure that your Committee would be of more value than it is at present.

Respectfully submitted,

J. Ralston Wells, Chairman;
W. L. Ashton,
Hubert A. Barge,
George R. Creekmore,
H. Quillian Jones,
M. A. Lischkoff.

On motion made, seconded and carried, the report of the Committee on Public Relations was adopted.

The report of the Committee on Cancer Control was submitted by Dr. F. Clifton Moor, as follows:

REPORT OF COMMITTEE ON CANCER CONTROL

During the past year The American Society for the Control of Cancer has sponsored and financed the organization of the "Woman's Field Army" on a nation-wide scope. The organization in each state is under the direct control of the Cancer Control Committee of that State Medical Society. In Florida, Mrs. Ralston Wells of Daytona Beach was selected as State Commander and last October she invited representatives from each of the twenty-odd women's organizations in the state to meet in Orlando with the Cancer Control Committee of the State Association, and established a set-up and plan of work. This meeting was attended by two members of your committee.

At the suggestion of the State Committee, the following set-up for Field Army was adopted:

1. A State Commander.
2. A Vice Commander for each District.
3. One or more Lieutenants in the territory corresponding to our county societies.

Your committee also planned a corresponding set-up with a committee from each County Society, and a Speakers' Bureau in each district in addition to the personnel of the Committee itself.

It is hoped that with this organization any interest in the subject of cancer manifested by any one of the various woman's organizations could, and perhaps would, result in a request for information. At the same time our organization, through the county or the district personnel, could furnish accredited speakers whenever requested. We believe it would greatly increase the opportunities for spreading information and, since the policy of your committee has been to limit its work to educational activities, it was felt that this arrangement would give greater potentialities than any heretofore suggested, especially since the American Society was to carry on at the same time a national publicity campaign through several widely circulated magazines.

Herewith is a schematic outline of the organizations:

National

American Society for Control of Cancer—National Commander, Mrs. W. B. Illig.

State

Chairman of State Cancer Control Committee—State Commander of Woman's Field Army, Mrs. Ralston Wells.

Each Committee District

A member of the State Cancer Control Committee—Vice Chairman.

Each County Society

County Committee on Cancer Control—One or more Lieutenants of the Field Army.

Respectfully submitted,

F. Clifton Moor, Chairman;
Joseph Halton,
S. C. Harvard,
Gerry R. Holden,
Lauchlin M. Rozier,
Lester L. Whiddon.

On motion made, seconded and carried, the report of the Committee on Cancer Control was adopted.

The report of the Committee on Medical Post-Graduate Course was read by Dr. T. Z. Cason, as follows:

REPORT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE

The details of the last Short Course for Doctors of Medicine in Florida including the financial statement have been published in the Florida Medical Journal, and need not be repeated here. The committee feels that the lecturers, their subjects, and the arrangement of the course last year reached the maximum we can hope to offer to the general practitioners of this state in a week's course. The attendance was only 99, although every doctor in Florida had in some way been informed of the course.

The committee has earnestly solicited the aid of and the suggestion of any member of the Florida Medical Association in bettering the course. We have tried as far as practicable to carry out all suggestions made.

We wish to call particular attention to the fact that the four previous courses have been conducted at a total expense to the Florida Medical Association of $61.49. However, if the courses are to continue, we shall be forced either to raise the registration fee or call on the Florida Medical Association to meet a fairly large deficit. This, we think, can be estimated at from $400 to $500 each year. Due to the fact that many graduate courses of this character are being held throughout the country, the lecturers whom we would like to have come to Florida are called upon for many sacrifices. It is the opinion of the committee, therefore, that in the future a reasonable honorarium should be allowed.

From the result of the course to be held this June at Orlando, we hope to get data which will enable us to draw some conclusion as to the advisability of holding the courses in different locations each year.

Respectfully submitted,

T. Z. Cason, Chairman;
George L. Cook,
Frank D. Gray,
E. Sterling Nichol,
Bricey M. Rhodes,
George C. Tillman.

On motion made, seconded and carried, the report of the Committee on Medical Post-Graduate Course was adopted.

The report of the Committee on Medical Economics was read by Dr. J. C. Vinson, as follows:

REPORT OF COMMITTEE ON MEDICAL ECONOMICS

I. The Committee on Medical Economics respectfully calls to your attention the fact that the individual income in the United States is less than $250.00 a year and that the income of each family is less than $1,100 a year; that during the height of prosperity in the United States 50 per cent of the individuals were not financially able to obtain adequate surgical and medical care. The Committee respectfully calls to your attention the program that is being inaugurated as incorporated in the Social Security Act. Your attention is called to the fact the program for syphilis alone involves approximately one-sixth of the population of the United States. This is only one of the many programs being initiated. You are aware that the treatment of veterans of every war has also eliminated this class from the private practice of medicine.

II. The recent economic survey made by your committee leads to the following conclusions:

a. The individual doctor realizes impending disaster and views the situation with a fatalistic mental attitude.

b. The county medical society as a unit of organized medicine has been totally useless in protecting the doctor or the public.

c. The state organization has beautifully impressed its inefficiency upon the public at large by a strict denial of any change in the practice of medicine as a whole.

d. The national leadership of medicine has developed no collective cohensive solution to the ripening process of a problem as old as organized medicine.

e. Organized medicine has denied its members the result of medico-economic laboratories that have and could be established through philanthropic grants.

f. The practice of medicine as it has existed in the past is over. The mental attitude of the individual doctor must undergo a radical change. The individual medical activity must be welded with collective groups for the greater security of the whole.

III. *Recommendations:*

That each county medical society under the supervision of the State Medical Association establish a bureau. The functions of this bureau will be:

1. A clearing house for the adjusting of, budgeting, and collection of fees.
2. Zoning patients financially.
3. Centralization of medical economic activities.
4. To act in a broad and general way toward the end that all patients irrespective of financial condition may receive adequate medical and surgical service.

That each county medical society under the supervision of the State Medical Association thoroughly familiarize its members with the purposes and aims as incorporated in the program under the Social Security Act.

Respectfully submitted,

J. C. Vinson, Chairman;
Albert H. Freeman,
Louie Limbaugh,
Daniel A. McKinnon,
Meredith Mallory,
Gerard Raap,
W. C. McConnell.

Dr. M. J. Flipse stated: "One recommendation is in conflict with the Constitution and By-Laws of the Dade County Society, specifically where it mentions the bureau being appointed for the zoning of fees. Our By-Laws specifically state that the Dade County Medical Society shall not specify ethical fees to be charged by the local physicians. I feel, therefore, that as a representative of that body, I must object to this particular section in the committee's report."

It was moved, seconded and carried that the report of the Committee on Medical Economics be received.

The report of the Committee as Representatives to the Industrial Council was read by Dr. J. C. Vinson, as follows:

REPORT OF COMMITTEE AS REPRESENTATIVES TO INDUSTRIAL COUNCIL

I. The medical situation in connection with the treatment of injuries suffered by workmen in the course of employment should be given very careful consideration by the Medical Association.

II. It is quite possible that we will be faced with a commercial spirit entering very deeply into the medical practice affecting compensation. The ethics of the profession may be discarded on many occasions by a class of practitioners interested more in financial gain than in the welfare of the patient. Clinics for treatment of compensation cases have been organized on a commercial basis, soliciting business openly from employers and insurance carriers. While we have at the present time a few extremely good clinics, we have in the process of organization others that seem undesirable, lacking hygienic and sanitary equipment.

III. We have had, also, charges of "lifting," that is, the transfer of a patient from one physician to another, or from one hospital to another without good cause. It has been said that claimants in many cases received too many treatments, or were returned to work before a complete cure had been effected. Either too many visits were ordered for the purpose of enlarging the medical bill, or insufficient treatment was given in the interest of economy.

IV. Collusion is not impossible between unscrupulous doctors and fraudulent claimants. This could easily be supplemented by a willingness on the part of certain doctors to give expert testimony on either side for pay. Rebating and fee-splitting are not uncommon. We have received charges that certain medical practitioners lack a personal interest in the progress of their cases, permitting the improper treatment by incompetent nurses and allowing physiotherapy treatments to go on indefinitely without visible results. Employers and insurance carriers have been charged with exercising undue control over the medical situation because of their privilege to select the physician and hospital rendering the requisite medical care. Added to this, we have

a continual controversy between attending physicians and the employers and carriers as to the reasonableness of medical fees.

V. Your Committee is faced with a tremendous task in making recommendations designed to correct the above situation. It is only natural to turn to other states which have had more experience in dealing with these problems. Those states, which seem to have been most successful, attempt first to qualify doctors to render service in compensation cases. A doctor may qualify by filing an application with the County Medical Society, stating whether he is engaged in general practice or devoted to a specialty. The County Medical Society then places him in the proper classification, assigning to him a symbol which identifies his line of work. He is then recommended by the Society for a license to be issued by the Industrial Commission, qualifying him for his particular line of work in compensation practice. In the event of unethical practice, the doctor is given a hearing before the proper authorities, and may be deprived of his license for compensation work. Exceptions, of course, are provided for in emergency cases.

It naturally follows, where the qualification method is used, the selection of the attending physician in a compensation case should not be confined entirely to the employer or insurance carrier. The injured employee, if any objection may exist, should be permitted to make another selection from qualified physicians.

The above recommendations would not be sufficient without the adoption of a medical fee schedule which would, in all cases, govern the charges made by the attending physician. There should also be proper "machinery" set up to deal with disputes that may arise as to proper attention or charges for services. This arbitration committee should be set up in such a way as to protect the interest of the doctors in the case. Some states create panels recommended by the Medical Associations from which arbitrators may be drawn.

Recommendations:

Every member of the county medical society may qualify for work for the Industrial Commission by filing a blank with his county medical society, stating whether he is engaged in general practice or whether he is a specialist. These blanks will be furnished by the county medical society. The county medical society will approve or disapprove his application and forward it to the State Medical Association or to a designated committee. He will then on approval be recommended for his license to be issued by the Florida Industrial Commission, qualifying him for his particular line of practice.

In the event of unethical practice, the usual course of procedure should follow with the exception that the findings be sent to the Executive Committee or to some designated committee of the State Medical Association for final decision. This committee should have the power to deprive the offending member of his license for compensation work.

The selection of the attending physician in a compensation case should not be confined entirely to the employer. The injured employee, should any objection exist, should be allowed to make another selection of any qualified physician.

There shall be established by the Florida Medical Association a committee which will deal with disputes that may arise as to proper attention and charges for services.

The New York State schedule of fees should be adopted by the Florida Medical Association.

Respectfully submitted,

J. C. Vinson, Chairman;
Louie Limbaugh,
John S. McEwan,
W. C. Payne,
Arthur H. Weiland.

It was moved, seconded and carried that the report of the Committee as Representatives to the Industrial Council be received.

The report of the Committee on Venereal Disease Control was read by Dr. E. T. Sellers, as follows:

REPORT OF COMMITTEE ON VENEREAL DISEASE CONTROL

A meeting of the special Committee on Venereal Disease Control was held April 5, 1937, at the Vinoy Park Hotel, St. Petersburg. Those present were: Drs. E. T. Sellers, chairman; R. D. Ferguson, Roy J. Holmes, Alvin L. Mills, Louis M. Orr, and Joe I. Turberville.

The meeting was called to order by the chairman, who explained its purpose. After discussion of each question suggested, the committee's recommendations are as follows:

1. *Methods of Reporting Venereal Diseases*

It is recommended that all venereal diseases be reported on a uniform blank, giving enough data for epidemiological information; this blank to be furnished by the State Health Department with a return post-free, self-addressed envelope.

2. *Epidemiological Investigations*

The Committee realizes that proper epidemiological investigations cannot be made unless patients are reported by names and addresses; however, due to embarrassment of the patients, especially in small communities, this cannot be done at the present time. It will be the responsibility of every physician to make epidemiological investigations, so far as possible, and see that the infectious contacts receive treatment. All patients who discontinue treatments before they are cured should be reported to the Health Department for action.

3. *The Private Physician*

It is a known fact that at the present time, syphilis is most inadequately treated by the great majority of physicians. A committee from the League of Nations made a world-wide study of the treatment of syphilis and has given us a detailed schedule for this disease and all of its phases, and it is recommended that all physicians who treat venereal diseases familiarize themselves with and follow this schedule.

There are no specifics for gonorrhea and apparently no two physicians treat it in a similar manner. There should be a general plan outlined for the treatment of this disease and its complications, which should be known to all physicians.

4. *Clinics*

The committee is of the opinion that free clinics, manned by capable physicians trained in the treatment of venereal diseases, should be conducted in cities where the population is sufficient to warrant a clinic.

In sections where the population does not warrant a clinic, it is recommended that private physicians treat all indigent patients, and receive a minimum fee from the Health Department, for these treatments.

It is recommended that the drugs for the treatment of syphilis be furnished by the Health Department for all free clinics and to all private physicians treating indigents or semi-indigents. This committee sees no logical reason why free drugs should be furnished to physicians for the treatment of full-pay cases.

5. *Laboratory Facilities*

It is recommended that the Health Department furnish laboratory facilities, within a reasonable proximity to all private physicians treating venereal diseases. These facilities should include dark field examinations, Kahn tests, cultures, and microscopic examination of slides, in order that an early diagnosis may be made.

6. *A Health Department Responsibility*

The laws of the state of Florida, at the present time, are sufficiently specific in regard to venereal diseases to aid the health officer in carrying forward a more adequate program of control and prevention. The committee recommends that the Health Department prosecute to the extent that it will discourage the treatment of venereal disease by those who are not licensed to do so.

7. *Education*

There can be no cooperation from the public until it has been fully informed as to the nature, prevalence, and tragic results of venereal diseases. It is recommended that this information, through radio, newspapers, magazines, pamphlets, and posters, be carried out by the Health Department.

The Committee feels that every senior high school class in the state of Florida should be informed concerning venereal diseases. We recommend that social hygiene be made an integral part of the health education program in junior and senior high schools, and be required for graduation from our senior high schools.

8. *Prophylaxis*

The Committee is of the opinion that prophylaxis should be included in our program for the public in general; first, from the standpoint of lessening the hazard of coming in contact with venereal diseases, just as we would in any other infectious disease; and, second, the application of scientific measures for the prevention of these diseases.

The sincere cooperation of the private practitioner is urgently needed for this venereal disease control campaign. The Committee recommends that a serological test for syphilis be made a routine procedure on every patient, both in his

private office and on admission to hospitals. This especially applies in early pregnancies.

The Committee is unanimous in its opinion that all patients who are able to pay regular fees be examined by private physicians and that examinations of health departments, city, county, and state, be confined to only laboratory procedure.

Respectfully submitted,

E. T. Sellers, Chairman;
R. D. Ferguson,
Roy J. Holmes,
Alvin L. Mills,
Louis M. Orr,
Joe I. Turberville.

On motion made, seconded and carried, the report of the Committee on Venereal Disease Control was accepted.

The report of the Inter-Relationship Committee was read by Dr. W. M. Rowlett, as follows:

REPORT OF COMMITTEE ON INTER-RELATIONSHIP

Your Committee reports a very active and successful year. In addition to a general meeting, held in Lake City on December 6th with similar committees from the dentists, druggists and nurses associations of the State, we have had a number of get-together meetings of local physicians, dentists, druggists and nurses.

We feel that this Committee has done much toward creating a better understanding between the above organizations. Through this friendly relation a very constructive program was adopted which has done much in establishing contact between laymen, politicians and our organizations. In nearly all of the larger counties of the State, local inter-relationship organizations were created and given the title of allied health councils. These councils were of special value during the last general election, as they aided materially in keeping their members, as well as the State Committee, acquainted with the political situation. While we were pleased at the enthusiasm shown in the election, we feel that we should be most cautious in dealing with political situations and that our influence would be far more reaching by concentrating on health and civic affairs, not losing sight, however, of the importance of having the best candidates elected to office and keeping together, as near as possible, a united strength to bring about this desirable end.

Respectfully submitted,

W. M. Rowlett, Chairman;
Thomas H. Bates,
Herbert L. Bryans,
Simon E. Driskell,
Louis M. Orr,
C. E. Tumlin.

On motion made, seconded and carried, the report of the Inter-Relationship Committee was received.

The report of the Committee on Tuberculosis and Public Health was read by Dr. M. Jay Flipse, by title only. Dr. Flipse moved that the report be received. It was seconded and carried that the following report be received:

REPORT OF COMMITTEE ON TUBERCULOSIS AND PUBLIC HEALTH

During the year this Committee held four meetings, one in Orlando on November 2, 1936, one in Jacksonville January 17, 1937, and two by mail. The duties of the Committee included the following activities:

1. Sponsored and participated in a Tuberculosis Institute for negro physicians held in Miami July 5 to 31, 1936, inclusive. The institute was financed jointly by the Julius Rosenwald Fund, the Florida Tuberculosis and Health Association and the Dade County Tuberculosis Association. Agencies cooperating included the above mentioned organizations, the Florida State Board of Health, the Dade County Medical Association, the Miami Board of Health, the Woman's Auxiliary to the Dade County Medical Association, and a number of other individuals and organizations. The Committee is participating at this time in the preparation of a program for a similar Institute to be held in July, 1937.

2. The Committee participated in the short course for physicians held in Gainesville June 22 to 27, 1936. A symposium on the Diseases of the Chest was sponsored by this Committee. Dr. W. Atwar Smith, Medical Director, Charleston Sanitarium, was brought to Florida to take part in the program. His trip was financed through the cooperation of the Florida Tuberculosis and Health Association. A symposium on Tuberculosis in connection with the 1937 physicians' short course is being planned at this time, and Dr.

P. N. Coryllos of New York, internationally known chest surgeon, will be the guest speaker.

3. The Committee on Tuberculosis and Public Health has served in an advisory capacity to the State Tuberculosis Board. The appointment of Dr. R. D. Thompson, formerly Superintendent and Medical Director of the Wisconsin State Sanitarium, to the position of Medical Director and Superintendent for Florida's new tuberculosis sanitarium at Orlando was made on recommendation of this Committee after a canvass of the qualified physicians in this state revealed no local physicians interested. No applications were received from Florida physicians for this position. We believe that Dr. Thompson with 15 years' experience in active sanatoria work from medical and administrative angles will merit the hearty support of the Florida Medical Association. This Committee hopes to continue to cooperate with Dr. Thompson and the State Tuberculosis Board in naming a consulting staff to the State Sanitarium and in other matters pertaining to the medical and public health aspects of this project.

4. This Committee has served in an advisory capacity to the Tuberculosis Bureau of the State Board of Health. Dr. Logie's program for the examination of school children as outlined in the March issue of the Journal of the Florida Medical Association meets with the approval of this Committee. Your specific attention is directed to the care that has been exercised to prevent encroachment of the State Tuberculosis work in the field of private medical practice. We believe each local medical society should cooperate in this project and that through Dr. Logie's work many private patients with tuberculosis will be brought under the observation of their family doctor while there is opportunity for a cure.

5. This Committee has acted in an advisory capacity to the Florida Tuberculosis and Health Association and has reviewed and approved for distribution the educational material to be used in the Annual Educational Campaign of this organization. This year the slogan for the campaign is "Uncover Tuberculosis by Modern Methods." The work of the Florida Tuberculosis and Health Association has for years been carried on with the close cooperation of the physicians interested in chest diseases. In this day of growing tendency toward the socialization of medicine we must congratulate ourselves in that the work of this powerful lay organization offers only assistance and support of the present system of private medical practice.

Respectfully submitted,

M. Jay Flipse, Chairman;
William C. Blake,
Spencer A. Folsom,
H. W. Henry
J. C. McSween,
Harry F. Watt,
Louis R. Bowen.

The report of the Committee on Maternal Welfare and Child Health was read by Dr. Homer Pearson, by title only. Dr. Pearson moved that the report be received. It was seconded and carried that the following report be received:

Report of Committee on Maternal Welfare and Child Health

The Committee wishes to report a very active year. We have had several well attended meetings at various places and times during the year. The majority of the Committee members seem to be intensely interested in the work and have been very cooperative.

We have been handicapped in several ways. We feel the first and greatest handicap has been that some of the members of our Association do not thoroughly understand what we are trying to do, and are becoming alarmed lest we become entangled with State Medicine. In a number of instances it seems very difficult to convince them that the excuse for this Committee is to try to avoid State Medicine.

It might be well for those who are too doubtful about this matter to know that through the Social Security Act the Federal Government has appropriated funds for Maternal and Child Health in every state in the Union. They are giving us an opportunity to cooperate by allowing us to formulate and assist in carrying out an adequate program in Maternal and Child Health. However, if we are not willing to do our share and more or less guide this work, there is no doubt but that it will be carried on in their own way, whether we like it or not. This Committee feels that we will do well to carry on and to continue to guide the work as far as possible.

Our second handicap has been relative to the Director of Maternal and Child Health of the State Board of Health. The field work of this Committee is carried on by this representative of the State Board of Health. We feel that we have

been unfortunate in having a director who though being extremely well trained in obstetrical work, was not too well trained in public health work and was perhaps a little over zealous and perhaps a little too impatient with those who did not entirely agree with his plans and actions. He, therefore, defeated his own purpose. We feel, however, that much could have been accomplished anyway, had the members of our association been a little more understanding and had tried a little harder to cooperate.

The State Health Officer and the State Board of Health have assured this Committee that they will permit us to pass on the next director for this department.

The program proposed by this Committee has been published in the State Journal and copies of it are available in the offices of the State Board of Health. Therefore, it will not be necessary for me to read it here in full. In outline it is as follows:

I. Medical Education.
II. Nursing Education.
III. Midwife Education.
IV. Lay Education.
V. Organization of Maternity and Well Baby Clinics.

That, we feel, is a good program. When another Director is chosen we propose to ask each County Society to set aside one meeting night for a member of this Committee to appear before it and go over the program thoroughly, so that our entire organization will be acquainted with this most important work.

Our maternal mortality rates indicate that we are greatly in need of an adequate program effectively carried out. A review of the mortality rates of our state shows that in many instances those societies which most strenuously opposed our program last year had the highest maternal mortality rates.

Respectfully submitted,

Homer L. Pearson, Chairman;
R. D. Ferguson,
James M. Hoffman,
T. C. Kenaston,
Robert G. Nelson,
S. R. Norris,
William W. McKibben,
Luther W. Holloway,
Councill C. Rudolph,
W. E. Sinclair.

The report of the Advisory Committee to the Woman's Auxiliary was read by Dr. Gordon H. Ira, as follows:

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The advisory committee met with Mrs. W. W. Harden, president of the auxiliary, and her board, in October, at Orlando. As the result of this meeting, the following charge was sent to each county auxiliary from our President, Dr. O. O. Feaster.

"It is with pleasure that the society acknowledges the splendid cooperation of the Woman's Auxiliary in the past, and after due consideration with the advisory board and officers of your auxiliary, it has been thought best, in favor of a more uniform program throughout the state, to emphasize only one project; and this project has been selected in the interest of every individual in the state, as well as the state as a whole. Its purpose will be to aid in ridding our state of a dreaded disease, a disease that might strike any member of our family and gain a foothold almost before we are aware of it, a disease that can be almost stamped out of Florida with proper management. And, it is with this thought in mind that your paramount charge for the coming year will be that of educating the high school students concerning tuberculosis.

"It is suggested that it be approached through an essay contest in each high school, with appropriate prizes for the winners, with arrangements to allow the three winners in each city to broadcast their essays. Your program chairman will furnish you with suggestions and rules concerning the contest.

"Aside from the above charge, several other items should be mentioned, namely:

1. The preparation of your exhibit for the state meeting in St. Petersburg.
2. Continue your cooperation with the cancer educational program.
3. Make available to various organizations in your city having a health committee authentic health literature, and with the cooperation of the president of your county medical society, furnish authentic health talks to such organizations as may desire a health program.
4. Continue distribution of the talk on health examinations for household servants."

The following rules were adopted and sent to the high schools:

Subject: "The Problem of Ridding Florida of Tuberculosis."

Note: The subject is intended to be very broad and is to cover all aspects, such as:

(a) The Recognizing of Tuberculosis.
(b) The Early Diagnosis of Tuberculosis.
(c) The Treatment of Tuberculosis.
(d) The Danger of Exposure to Tuberculosis.
(e) The Necessity of Isolation of Tuberculous Patients.
(f) The Comparison of the White Plague (Tuberculosis) with other plagues.

Prizes: State: 1st, $25.00 in cash and the honor of broadcasting the essay. 2nd prize, $15.00; 3rd prize, $2.50 in cash.

Eligibility: Any student of a Junior or Senior High School of Florida is eligible to enter the contest.

Length of Essay: 1,000 to 1,500 words.

Form: (1) All essays must be *typed* with *double* spacing.

(2) All pages of essays must have *margins* of 1½ inches at top, and of 1 inch at either side, and at bottom of paper.

(3) Name of the writer of the essay is *not* to appear on the essay, but it is to be sealed in an envelope bearing the number of the contestant, as given to him by his English teacher.

Time Limit:

1. Essays in each school must be submitted by March 1.
2. County essays—submitted March 15.
3. State essays—submitted April 1.
4. Prizes awarded—April 15.

Judging:

1. In each high school, essays will be judged by a committee of three teachers appointed by the principal of the high school.
2. Each school will in turn submit its three best essays to the county judges.
3. The county judges will select the one best essay, to be submitted to the state judges.

Judges:

1. Local: A committee of three teachers appointed by the principal from the respective school.

Suggestion: One member to be selected from the science department.

2. County: (a) One member of the county board of public instruction.
(b) One doctor of the county selected by the County Auxiliary of the Medical Association.
(c) One English teacher from the county.

3. State: Dr. M. J. Flipse, Miami, State Chairman of the Tuberculosis Committee of the Florida Medical Association.
Colin C. English, State Superintendent of Public Instruction.
Dr. W. G. Dodd, Dean of the College of Arts and Sciences, and head of the Department of English, Florida State College for Women, Tallahassee.

Material: Ample reference material may be obtained from the County Auxiliaries of the Medical Association, and the State or County Tuberculosis Association.

Mrs. S. M. Copeland, Chairman;
Mrs. E. G. Peek,
Mrs. E. W. Veal.

This contest, not over yet, is a grand success. The Tuberculosis Association cooperated splendidly in supplying literature. The unexpected enormous response depleted the supply of literature, and for the benefit of the students in Jacksonville, the Tuberculosis Association supplied abundant information through the press.

In a recent American Medical Association editorial the following statement in regard to the auxiliary was made: "The work of the Woman's Auxiliary which was formerly included in The Bulletin, has now assumed such proportions as to merit a special page for its activities."

If you have followed the Woman's Auxiliary page in the Journal of the American Medical Association, you will have noticed, from time to time, very favorable mention of Florida activities.

Your committee has one recommendation to make, and suggests its adoption with the adoption of this report: namely, that the secretary be requested to suggest to each county society, where a woman's auxiliary exists, that a county advisory committee be appointed, similar to the state com-

mittee, so that each auxiliary may better cooperate with that society.

Respectfully submitted,
GORDON H. IRA, Chairman;
L. C. INGRAM,
W. C. ROBERTS,
A. L. WALTERS,
J. L. CHALKER,
R. L. CLINE.

On motion made, seconded and carried, the report of the Advisory Committee to Woman's Auxiliary, was received.

Dr. Meredith Mallory read his report as delegate to the American Medical Association, as follows:

REPORT OF DELEGATE TO AMERICAN MEDICAL ASSN., DR. MEREDITH MALLORY

To try to report the entire proceedings of the House of Delegates of the American Medical Association would be most uninteresting, to begin with, and, further, it is given in the Journal so that anyone may read that part which interests him. However, there is one phase of the activities of the House of Delegates that merits the attention of every physician of this Association and that is the work being done to combat the economic trend of the times. This work cannot and should not be minimized. In spite of the endeavor of a few who see no trouble brewing, either through their inability to grasp the situation or who have no interest in it because they feel it will not affect them; we, the members of the medical profession, are going to have thrust upon us a new set-up and if we do not fight it now, by all means, the coming is not far off.

There are a few men whose practices are of the type that the change will in no way affect them, but these men are in the great minority and, unfortunately, many of them are not interested in their fellow practitioners. This group probably comprises one-tenth of the profession. At the other end of the scale there is another group who will derive benefit, which while not great, may mean the difference of a few meals. This group is represented by possibly three-tenths, or as the common expression of the day, the lower one-third. Between these two groups lies the greatest number of the profession—the back bone. Any form of socialized medicine will drag them down to the level of the second group mentioned above. Roughly speaking, this is going to be the economic effect on the profession.

It is impossible to go into detail in the other phases of socialized medicine, but I do want to draw your attention to the fact that it is for this problem that the officers and delegates of the American Medical Association are striving to find a solution. We, in Florida, have seen scattered attempts to bring some form of socialized medicine here and if this problem is going to be met, there must be the utmost cooperation between our state organization and the national. You who are members of the House of Delegates of the Florida Medical Association have a distinct duty that you owe to the membership to do all in your power to meet the problem in a manner that will be advantageous both to the public and to the profession.

Respectfully submitted,
MEREDITH MALLORY.

Dr. Mallory's report as delegate was endorsed by Dr. Herbert L. Bryans, the other delegate to the A. M. A., who read his report by title only. On motion made, seconded and carried, these reports were received.

REPORT OF DELEGATE TO AMERICAN MEDICAL ASSN., DR. HERBERT L. BRYANS

RESUME OF THE PROCEEDINGS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION AT THE EIGHTY-SEVENTH ANNUAL SESSION AT KANSAS CITY MAY 11 TO 15, 1936

The president, Dr. James S. McLester, in his annual address, touched upon the solidarity of the medical profession and the loyalty of its members to the American Medical Association. He said that during the past two years it appeared that disaster was just ahead, when government, in its effort to extend social reform, appeared ready to reach out for control of medical practice. But the leadership over a united medical profession and its influence on public opinion was wise and effective with no change taking place. He asked the question, "Can we afford to rest here?" Will the politicians of the near future, anxious to carry governmental subsidies still further, extend their control, as politicians have already done elsewhere, to medical care?

He emphasized the attitude of the A. M. A., as in the past, should be one of close attention to the medical needs of the American people and of alert preparedness to meet these needs. We have been sound in our position that any form of governmental control of the practice of medicine would be fatal to medical progress and that the real sufferers in the end would be the American

people. Our soundness on this point should not lead us to deny that there are still many problems, and that the solution of these, so far as medical care is concerned, will certainly call for intelligent and constructive thought on the part of the men that provide medical care in the various communities of the country. The fermenting of the public consciousness of evolutionary progress as it relates to medical care will continue. The president spoke of several important committees of the A. M. A. and their wonderful accomplishments. The address showed considerable thought and in my opinion was a master one.

Dr. B. T. King, of Washington, read the message from Dr. J. Tate Mason, President-elect of the A. M. A., who was prevented from being in attendance because of illness. Since he has died.

In part the message said that during the past year he had spoken before approximately 8,000 physicians and that he was surprised to find out how little the average American physician knows about the work that is being carried on at the headquarters of the A. M. A.

He said there were many fantastic and weird suggestions on economics, but on the whole the physicians can be divided into three groups with respect to their ideas on medical economics. The message continued with a detailed discussion of these three groups.

In the report of the Judicial Council there is one paragraph I think should be quoted, "There are at present several members of this Association who are either serving sentence for felonies or have recently terminated such sentence. Their names are carried as members in the A. M. A. Directory. This condition is brought about by County Societies and State Associations neglecting or refusing to expel such felons. The Judicial Council believes that the continuance of such men in membership, and the publication of their names as members in the A. M. A. Directory, are beneath the dignity of this Association and open the door to harmful criticism of the organized profession."

Among other things the Committee on Medical Education emphasized the importance of the teaching of medical economics in medical schools.

Dr. T. C. Routley of the Canadian Medical Association extended an invitation to the A. M. A. to meet with them at some future time in the City of Toronto.

In the report of the Reference Committee on Legislation and Public Relations of the activities of the Bureau of Legal Medicine and Legislation and Bureau of Medical Economics, they call to attention the Social Security Act, especially to the suggestion that the medical profession cooperate in good faith in carrying out the provisions of this Act. However, the Committee emphasized the fact that the basic requirements of federal legislation are so broad as to permit the creation within the State Social Legislative structure of conditions which may be very difficult of administration in a manner acceptable to physicians if the local profession does not participate in the organization of their state structures. This committee reported that no state by legislation has established any systems of compulsory state health insurance. They recommended the enactment of uniform state narcotic drug acts, also the inclusion of regulations in control of production, preparation and distribution of Cannabis and that barbituric acid compounds and other substances peculiarly potent for harm when self administered be sold only on the prescription of physicians, dentists or veterinarians.

Where legislation is enacted by which gunshot and other wounds are made reportable by physicians, the medical profession should insist that the same requirements be imposed on every other person having knowledge of the wound and the possible conditions under which it was inflicted.

There was one important question raised as to the advisability of carrying on all consultation and correspondence directed to the Bureau of Legal Medicine and Legislation through the office of the constituent state associations. The facility of this plan would depend on the willingness and capacity of the organization of the State Associations to care for the additional matter which would pass through their respective offices. The subject will be discussed again in June.

The experimental plans for the distribution of medical care is still under study. Much will depend on a careful evaluation of these methods and the measure of success attained after a sufficient period of operation.

The methods of care of the indigent sick are so widely at variance in the respective states and are undergoing such constant change that no opinion of value was rendered.

There is being compiled for distribution data on the "Relation of Medical Ethics and Medical Economics", suggesting careful study of the subject in the various component county societies

where the responsibility for the enforcement of ethical principles must reside.

In "Group Hospitalization" they reported there is much reason to suggest caution.

There was considerable discussion on contraceptives and the Committee on Contraceptive Practices and Related Problems recommended:

1. That a committee continue the study of Birth Control.
2. Steps should be taken by some responsible group to develop standards for judging contraceptive materials.
3. To record disapproval of propaganda directed to the public by lay bodies, organized solely for the purpose of disseminating (without consideration or restraint) contraceptive information. They deplored the support of such agencies by members of the medical profession, and felt that an entirely false sense of values with respect to the important function of childbearing and of parenthood had been created by the activities of such organizations.

There were a number of important resolutions presented, most of which were referred to committees for study and to be reported back this year.

Among the distinguished foreign guests present were:

Lord Horder, London, England.

Leon Asher, Bern, Switzerland.

Wolfgang Henbner, Berlin, Germany.

The president-elect was Dr. J. H. J. Upham, Columbus, Ohio.

Vice-President, Dr. Charles Gordon Heyd, New York City.

Secretary, Dr. Olin West.

Atlantic City was chosen for the 1937 annual session.

There was a total registration of 6,824 with thirty-one from Florida.

It is impossible to give you a complete report of the proceedings in the House of Delegates of the A. M. A. in the short time allotted me; therefore this report has been most brief and in no way does it cover the entire subject.

I have enjoyed the privilege of serving as one of the Delegates to the A. M. A. and in conclusion wish to express again my appreciation of the honor.

Respectfully submitted,

HERBERT L. BRYANS.

The report of the Committee on Necrology was submitted by Dr. C. D. Christ, as follows:

REPORT OF COMMITTEE ON NECROLOGY

During the past year, our Association lost, by death, the members whose names are listed below:

John Miller Beggs, Chattahoochee
John R. Cason, Delray Beach
W. A. Claxton, Oteen, North Carolina
J. William Ebert, West Palm Beach
Francisco M. Fernandez, Miami
Joseph Norman Fogarty, Daytona Beach
James Mullins Grantham, Tampa
Genous S. Hodges, Marianna
James H. Hodges, Gainesville
Austin James Kemp, Miami
Roy H. McKay, Miami
Daniel W. McMillan, Pensacola
Dalton Y. Rosborough, Palatka
Jesse J. Saxton, Tampa
Henry M. Strickland, Live Oak
Samuel C. Wood, Leesburg

When possible, obituaries have appeared in the Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we, at this time, stand in a moment of silence, in reverence and respect to the memory of our departed colleagues.

CALVIN D. CHRIST, Chairman;
CHADBOURNE A. ANDREWS,
P. J. HUDSON,
E. L. HUGGINS,
WILLIAM W. MCKIBBEN,
GEORGE W. POTTER.

The next order of business being the presentation of invitations from the County Societies to entertain the convention next year, Dr. Homer Pearson extended an invitation from the Dade County Medical Society for the Association to go to Miami, calling attention to the fact that the Association had not met in Miami since 1919.

Dr. H. A. Day extended an invitation from the Orange County Medical Society for the Association to go to Orlando.

The Secretary read an invitation from the Bay County Medical Society to go to Panama City and Dr. W. C. Roberts withdrew the invitation in favor of the other two cities.

It was moved, seconded and carried that the vote be unanimous on the selection of Miami as the meeting place next year. Motion prevailed.

The Secretary then read an application for charter for the Washington-Holmes County Medical Society.

Dr. M. Jay Flipse moved that the application for charter be referred to the Executive Committee for investigation as to the proper course of procedure and with the authority to issue a charter if the investigation evinced the desirability of establishing this society. This motion was seconded and carried and the application for charter from the Washington-Holmes County Medical Society was referred to the Executive Committee.

There being no further business, on motion, the session adjourned to meet Tuesday at 5 p. m.

PUBLIC MEETING

A Public Meeting was held in the First Methodist Church at 7:45 p. m., Monday, April 5, with Dr. Morris Fishbein, Editor of Journal of American Medical Association and of Hygeia, as the guest speaker. Dr. Fishbein delivered an address on "Food Fads and Follies."

SECOND SCIENTIFIC ASSEMBLY

The Second Scientific Assembly was held Tuesday, April 6, 9:00 a. m., Dr. Leigh F. Robinson presiding. The following papers were read and discussed:

7. "Acute Appendicitis in Children," Dr. Douglas D. Martin, Tampa.
8. "Cooperation of State Board of Health and Medical Profession," Dr. W. A. McPhaul, Jacksonville.

SECOND GENERAL SESSION

The General Assembly reconvened at 10:00 a. m., Tuesday, April 6, in the Ball Room of the Vinoy Park Hotel, with Dr. O. O. Feaster in the Chair.

Meeting called to order.

The following report of the Secretary-Treasurer-Editor and Business Manager was read by Dr. Shaler Richardson:

REPORT OF SECRETARY, TREASURER, EDITOR OF THE JOURNAL, DR. SHALER RICHARDSON, AND BUSINESS MANAGER, DR. STEWART G. THOMPSON

To the President and Members of the Florida Medical Association in Session at St. Petersburg, Florida:

MEMBERSHIP

There was a net increase of 61 paid members in the Association during 1936. Last year the paid members totaled 1,126, as compared with the total of 1,065 for 1935. A total paid membership for 1936 of 1,126 surpasses all membership records in the history of the Association. This record was undoubtedly influenced by new doctors settling in Florida. In addition, it is conclusive evidence of the interest and solidity of the membership of the organization.

The State Association is made up of 32 component parts and the splendid showing for the state is made possible through the efforts and enthusiasm of each component society. Only four county medical societies failed to collect one hundred per cent of the state dues of their membership for 1936. This is a real achievement and is without doubt the best record to date. There were only seven members reported for 1936 who failed to pay their state dues. The Dade County Medical Society is way out in front as to total membership, having 220 paid members for 1936. Duval County Medical Society is second, with 151 paid members and Hillsborough County Medical Society is third, with 118 paid members. The 28 component societies reporting one hundred per cent of their members' dues paid for 1936 are as follows:

Alachua
Bay
Brevard
Broward
Columbia
Dade
Duval
Jackson
Lake
Lee
Leon-Gadsden-Liberty-Wakulla-Jefferson
Madison
Manatee
Marion
Monroe
Orange
Pasco-Hernando-Citrus
Pinellas
Polk
Putnam
St. Johns
St. Lucie-Okeechobee-Indian River-Martin
Sarasota
Seminole
Sumter
Taylor
Volusia
Walton-Okaloosa

JOURNAL

During the past fiscal year (eleven months), 14,950 Journals were mailed from the business office. During the previous fiscal year there were 15,240 Journals mailed out. The increase in the number of Journals printed depends on the size of the membership and the number of advertisers. During the past year there was no increase in the printing cost schedule of the Journal. The total amount of money spent for printing increased, but was due to the increase in the number of Journals printed, rather than to an increase in the printing rate. The Record Company of St. Augustine has printed the Association's Journal for many years and their work has been very satisfactory. The Association is

indeed fortunate in having the services of a printing company which cooperates in keeping down the cost of printing and at the same time turns out such excellent work.

The number of papers offered for publication in the Journal has steadily increased. The problem at present is to find space for the worthy articles submitted by our members. Special recognition is due your Committee on Publication. Dr. Walter C. Jones and Dr. Herbert E. White have given generously of their time in reviewing the papers presented for publication in the Journal. It is a tedious and laborious task and members of the Publication Committee have worked throughout the year without special recognition. It is, therefore, with pleasure that attention is called to the efficiency and unselfish efforts put forth by the members of this Committee.

A new department has been added to the Journal which will be known as the Abstract Department, with Dr. Kenneth A. Morris as abstract editor. This department was shown for the first time in the March, 1937, Journal. The purpose of this department will be to recognize articles by our members, published in Journals other than the Florida Medical Journal. Your editor feels that this will be a very interesting and worthwhile department and will make our Journal more valuable to the members of this Association. Your business office is well equipped to assist the Abstract Department. Some years ago the Index Medicus was purchased, and through this complete index, it will be very easy to pick up all the articles published in Medical Journals by our members. This Index Medicus is used every working day in the office and has been very valuable for reference, in checking bibliographies of original articles, looking up the official names of Journals and authors. The money spent for this Index Medicus was an investment wisely made.

FINANCES

The net increase of receipts over disbursements for the past fiscal year was $4,298.60 as compared with a total of $2,102.19 for the previous year. This increase last year was partially accounted for in the increase of $2.50, additional state dues, which went into effect January 1, 1937. Your Legislative Committee will have considerable necessary expense this year and will be able to do their work more effectively because of this additional revenue which has been made available. Another reason for the net increase of our finances is, of course, the splendid efforts made by the various component societies in collecting the state dues from their individual members.

The income from advertising was $3,035.75 as compared with a total of $3,364.58 for the previous year. The smaller income shown for the past year is on a basis of eleven months, owing to the fact that this year's annual meeting is held one month earlier. A comparison of twelve months against the twelve-month fiscal year previous will show an increase in advertising income. The earnings from the sale of exhibit spaces, up to the time the books were closed was $1,092. This total, however, will be increased, as more exhibit spaces will be sold after the close of the books. The sale of exhibit spaces is governed by the size of the headquarters hotel. The Vinoy Park Hotel is very large; therefore, the sale of exhibit spaces will this year reach a maximum total. Sixty per cent of all monies collected from the sale of exhibit spaces is turned over to the entertaining society to defray the local expense. Forty per cent is retained by the State Association to defray the expense of selling the exhibit spaces, postage, supplies, clerical help, transportation of employees to the convention, and other incidentals.

OFFICE

The volume of work in the business office is steadily increasing and we hope its usefulness to the membership is increasing proportionately. Your officers and committees have used the facilities offered, more and more frequently. It is your office and your employees are anxious and willing to serve you in every way possible.

In previous reports the office equipment and activities have been carefully outlined so a repetition is unnecessary. One new piece of equipment has been added during the past year, with the approval of the Executive Committee. It is an addressograph, embosser and name plate cabinet. This unit in the equipment will make it possible to address the Journal each month from our name plate list, and it can be used for circular letters and for mailing out special information to the members. This addressograph is a very necessary unit and will be used continually each month. Owing to production difficulties, only part of this equipment has been delivered but it

is hoped that the unit will be complete very shortly. For your information we might mention that in the past an addressograph has been used which belongs to another office, but the work in our Association has reached the point where our own equipment will be much more satisfactory.

Booklets were mailed out to all members for the Legislative Committee, minutes kept for the Executive Committee and various circular letters mimeographed and mailed out during the year. There were 5,765 first-class letters typed and mailed out, in addition to the work on the mimeograph. There were 3,592 pieces of mail received during the year.

Proposed changes in the By-Laws were sent to the business office for verification. This is an indication of cooperation that will stabilize the organization. The proposed changes were carefully checked and prepared in mimeograph form so that the members of the House of Delegates will be familiar with the proposed changes and better able to vote what they think is right and proper. This thoughtfulness on the part of those wishing to make changes in the By-Laws will prevent hasty action which might be in conflict with some other By-Law, or the Constitution.

At the last annual meeting your secretary was instructed to write letters to Dr. W. W. Bauer and Dr. Morris Fishbein, and also a letter to the Steamship Company. These letters were dispatched promptly after the meeting. At the last annual meeting the secretary was instructed also to circularize the secretaries of the component societies and secure copies of their Constitutions and By-Laws for filing in the business office. A letter was, therefore, mailed to each component society secretary with the following results:

Constitution and By-Laws were received from Broward County Society, Duval County Society, Orange County Society, Pasco-Hernando-Citrus County Society, and Pinellas County Society. The following county societies reported that they had no Constitution and By-Laws: Columbia, DeSoto-Hardee-Highlands, Lake, and St. Lucie-Okeechobee-Indian River-Martin. No reports were received from the other societies.

The 1936 membership roster as shown in the February Journal, has been run off in reprint or booklet form and a copy mailed to each member of the Association, all of the hospitals in the state, advertisers, and will be mailed to anyone applying. This roster of the Association for 1936 will be very valuable for reference and will also recognize those doctors in the state who are members in good standing of the State Association and the American Medical Association. A few advertisements were sold for this booklet, which will defray the expense of printing and mailing and leave a small profit for our treasury.

The books and records of the Association are open to our members and we will be glad to answer inquiries of any nature. The books have been audited by Ford and Colley and a certification thereof is incorporated in the statements which follow.

Respectfully submitted,

SHALER RICHARDSON,
STEWART G. THOMPSON.

FORD & COLLEY

CERTIFIED PUBLIC ACCOUNTANTS.

Jacksonville, Fla., April 3, 1937.

Dr. Shaler A. Richardson,
Treasurer,
Florida Medical Association,
Jacksonville, Florida.

DEAR SIR:

We have examined the attached statements of Cash Receipts and Disbursements of Florida Medical Association, Incorporated, for the period begun April 14, 1936, and ended March 22, 1937, both inclusive. These statements have been prepared by Dr. S. G. Thompson, Business Manager of the Association, and the Florida Medical Journal, and correctly reflect the total amounts received and disbursed as shown by the books of account.

We have checked the total of the collections shown by the statements with the corresponding entries in the cash-journal; the additions of the cash-journal were checked and a trial balance prepared as of March 22, 1937.

Bank accounts were reconciled with the bank statements and pass books and confirmations were obtained from the bankers.

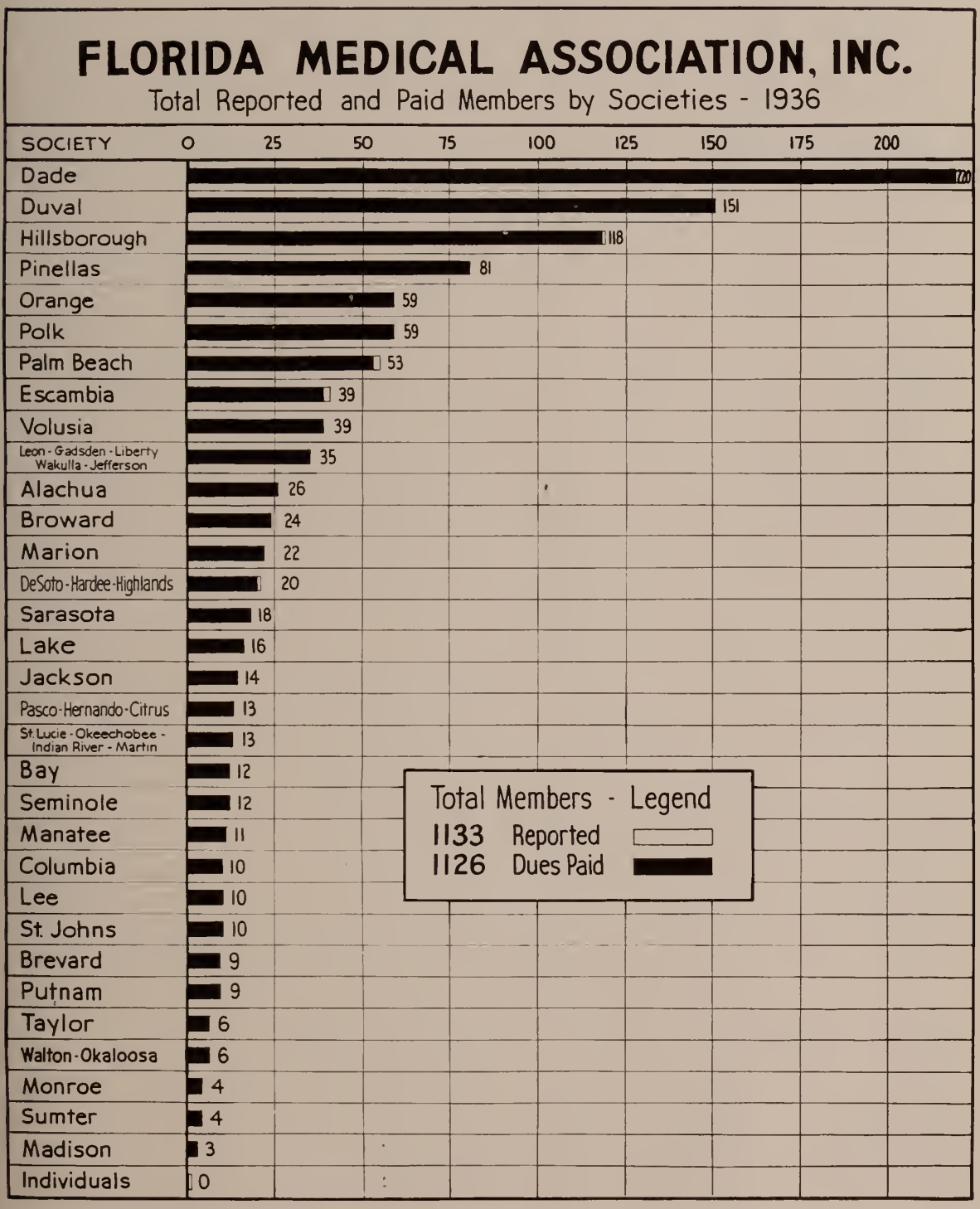
As we do not have access to the records of the various County Societies for the purpose of checking the remittances of dues, attention is directed to Exhibits "D" and "F" which give details as to this matter. The inspection of these exhibits by the officers of the respective societies will enable them to verify the correctness of the remittances shown.

Income from Journal advertising was verified substantially by comparison with a statement of the contracts with advertisers.

The ten United States Treasury bonds, par value $1,000.00 each, were verified by us with The Atlantic National Bank of Jacksonville, Florida.

Yours very truly,

FORD & COLLEY.


FLORIDA MEDICAL ASSOCIATION, INC.
Total Reported and Paid Members by Societies - 1936
SOCIETY
0
25
50
75
100
125
150
175
200
Dade
Duval
151
Hillsborough
118
Pinellas
81
Orange
59
Polk
59
Palm Beach
53
Escambia
39
Volusia
39
Leon - Gadsden - Liberty Wakulla - Jefferson
35
Alachua
26
Broward
24
Marion
22
DeSoto - Hardee - Highlands
20
Sarasota
18
Lake
16
Jackson
14
Pasco - Hernando - Citrus
13
St. Lucie - Okeechobee - Indian River - Martin
13
Bay
12
Seminole
12
Manatee
11
Columbia
10
Lee
10
St. Johns
10
Brevard
9
Putnam
9
Taylor
6
Walton - Okaloosa
6
Monroe
4
Sumter
4
Madison
3
Individuals
0
Total Members - Legend
1133 Reported
1126 Dues Paid

CONSOLIDATED CASH STATEMENT

April 13, 1936, through March 22, 1937

Receipts

Cash in Bank, April 13, 1936		$18,412.76
Dues Collected (Exhibit "D")	$10,217.50	
Earnings from Advertising (Exhibit "E")	3,035.75	
Subscription and Miscellaneous Sale of Journal	34.75	
Bonus from Cooperative Medical Advertising Bureau	255.09	
Interest on Savings and Investment	355.14	
Earnings—Technical Exhibits (Exhibit "C")	1,092.00	
For Prosecutions Account (P.C.M.S.)	254.47	15,244.70
Total Cash to be Accounted for		$33,657.46

Disbursements

General Fund Expenses (Exhibit "A")	$ 3,953.06	
Journal Expenses (Exhibit "B")	5,246.69	
Technical Exhibit Expenses (Exhibit "C")	$131.82	
To Entertaining Society	625.20	757.02
Committee Expenses	357.41	
Prosecutions (P.C.M.S.)	400.00	
Refund (P.C.M.S.) Exceeded Maximum	54.47	454.47
Furniture and Fixtures	150.78	
Library	18.80	
Federal Tax	7.87	10,946.10
Balance in Bank, March 22, 1937		$22,711.36

EXHIBIT "A"

CASH STATEMENT—GENERAL FUND

April 13, 1936, through March 22, 1937

Receipts

Cash as per last audit		$17,541.39
Back dues collected (Exhibit "D")	$1,477.50	
Current dues Collected (Exhibit "D")	8,740.00	10,217.50
Interest on Savings and Investment		355.14
For Prosecutions Account		254.47
Total Cash to be Accounted for		$28,368.50

Disbursements

Postage and Supplies	$ 272.52		
Telephone and Telegraph	143.51		
Salaries	2,868.10		
Convention Expense	136.23		
Traveling Expense	60.41		
Legal Counsel	91.67		
Auditing Expense	12.50		
Office Rent	165.00		
Messenger Service	4.25		
Bond of Treasurer	18.75		
Express, Freight and Dray	6.36		
Reprints, Constitution and By-Laws	40.70		
Incidental Items	13.00		
Bank Exchange	2.15		
Transportation Expenses, A. M. A. Delegates	117.91	$3,953.06	
Committees:			
Post-Graduate Course	$ 2.00		
Legislative	228.30		
Public Relations	66.21		
Hospital	2.00		
Maternal Welfare	11.17		
Medical Economics	1.50		
Scientific Work	46.23	$ 357.41	
Prosecutions (P.C.M.S.)	400.00		
Refund (P.C.M.S.) Exceeded Maximum	54.47	454.47	
Furniture and Fixtures		150.78	
Library		18.80	
Federal Tax		7.87	
To Journal Fund (Cost above income of Journal)		1,921.10	6,863.49
Cash Balance			$21,505.01

EXHIBIT "B"

CASH STATEMENT—JOURNAL FUND

April 13, 1936, through March 22, 1937

Receipts

As per last audit		$0.00
Earnings from Advertising (Exhibit "E")	$3,035.75	
Subscription and Miscellaneous Sale of Journal	34.75	
Bonus from Cooperative Med. Adv. Bureau	255.09	
From General Fund	1,921.10	
To be Accounted for		$5,246.69

Disbursements

Postage and Supplies	$ 251.95	
Printing of Journal and Electrotypes	3,389.50	
Telephone and Telegraph	65.36	
Salaries	1,481.23	
Auditing Expense	12.50	
Bond of Treasurer	18.75	
Drayage	13.75	
Messenger Service	5.25	
Binding of Journals	8.40	5,246.69
Cash Balance		$0.00

EXHIBIT "C"

CASH STATEMENT—EXHIBIT FUND

April 13, 1936, through March 22, 1937

Receipts

Cash as per last audit	$ 871.37	
Earnings from Technical Exhibits	1,092.00	
Total Cash to be Accounted for		$1,963.37

Disbursements

Postage and Supplies	5.91	
Telephone and Telegraph	10.63	
Salaries	14.63	
Convention Expense	67.80	
Floor Plan and Electrotype Printing	24.25	
	8.60	131.82
To Entertaining Society	625.20	
(Pinellas County Medical Society)		757.02
Cash Balance		$1,206.35

EXHIBIT "D"

Dues collected April 13, 1936, through March 22, 1937

Name of Society	Total Members	No. Paid Members	No. in Arrears	1937 Dues Collected	Back Dues Collected
Alachua	27	19	8	$ 180.00	$ 22.50
Bay	12	10	2	90.00	22.50
Brevard	10	3	7	20.00	45.00
Broward	28	28	0	270.00	
Columbia	8	5	3	40.00	
Dade	262	157	105	1,560.00	225.00
DeSoto-Hardee-Highlands	19	19	0	180.00	90.00
Duval	156	113	43	1,120.00	232.50
Escambia	39	25	14	240.00	120.00
Hillsborough	97	88	9	870.00	120.00
Individuals	7	0	7		
Jackson	15	12	3	110.00	45.00
Lake	17	14	3	130.00	7.50
Lee	10	9	1	80.00	
Leon-Gadsden-Liberty-Wakulla-Jefferson	35	30	5	290.00	105.00
Madison	4	4	0	30.00	
Manatee	11	11	0	100.00	
Marion	21	21	0	200.00	
Monroe	3	3	0	20.00	
Orange	58	54	4	530.00	45.00
Palm Beach	55	49	6	480.00	22.50
Pasco-Hernando-Citrus	13	11	2	100.00	37.50
Pinellas	86	75	11	740.00	15.00
Polk	58	41	17	400.00	210.00
Putnam	9	9	0	80.00	
St. Johns	11	10	1	90.00	7.50
St. Lucie-Okeechobee-Indian River-Martin	14	13	1	120.00	37.50
Sarasota	17	10	7	90.00	15.00
Seminole	13	13	0	120.00	
Sumter	4	4	0	40.00	
Taylor	7	7	0	60.00	7.50
Volusia	40	33	7	320.00	45.00
Walton-Okaloosa	5	5	0	40.00	
Totals	1,171	905	266	$8,740.00	$1,477.50

$1,477.50 Back Dues Collected

$10,217.50 Total Dues Collected

EXHIBIT "E"

EARNINGS FROM ADVERTISING

April 13, 1936, through March 22, 1937

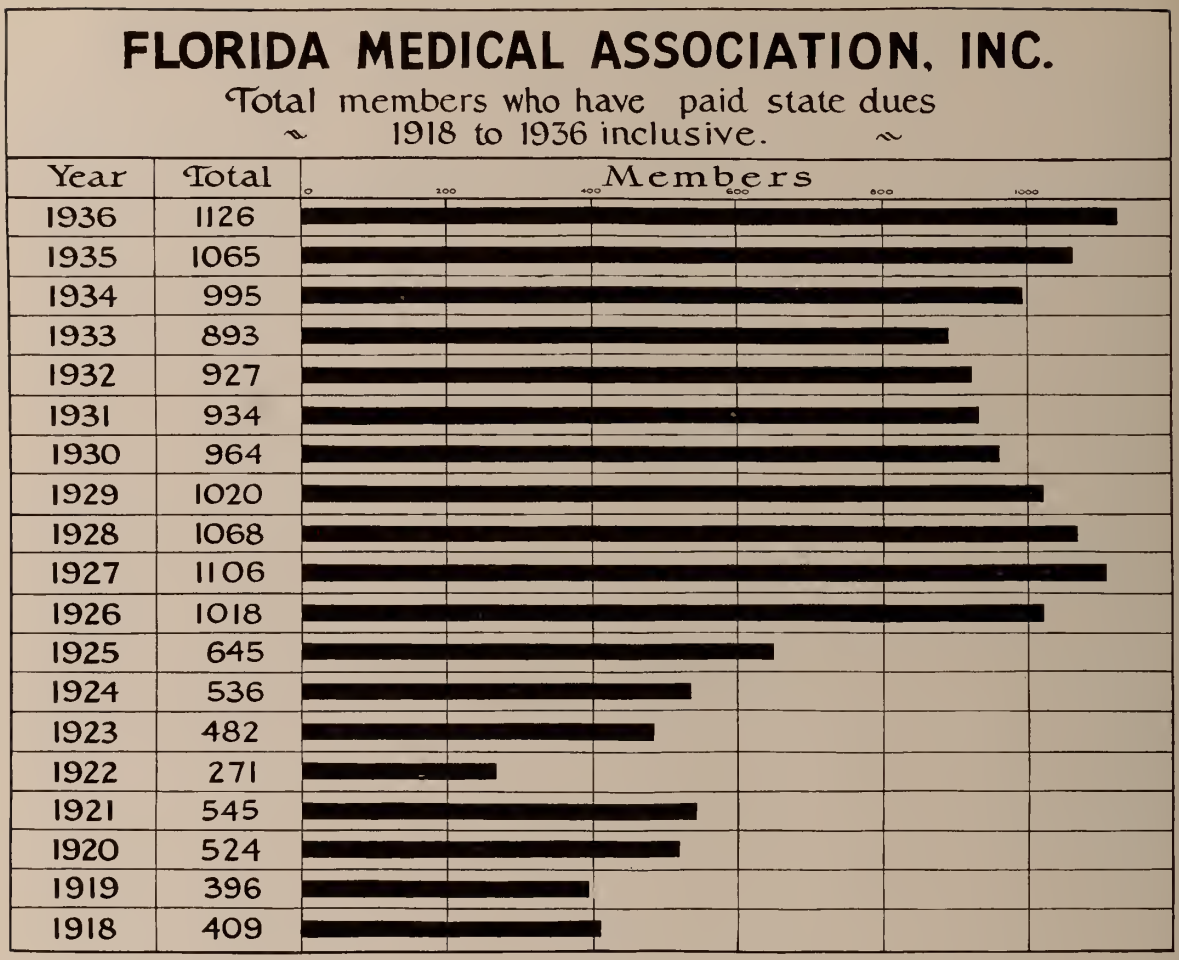
May, 1936	$ 216.53
June	300.55
July	190.04
August	324.70
September	316.24
October	299.12
November	300.06
December	281.39
January, 1937	238.04
February	308.47
March	260.61
Total	$3,035.75

EXHIBIT "F"

NAMES OF MEMBERS DROPPED BY REASON OF REMOVAL, NON-PAYMENT OF DUES, ETC.

April 13, 1936, through March 22, 1937

Name and Address	Dues Not Paid 1936	1937
COLUMBIA COUNTY MEDICAL SOCIETY:		
Strickland, Henry M. (dec.), Live Oak	7.50	
DADE COUNTY MEDICAL SOCIETY:		
Donald, Ernest, Oklahoma City, Okla..	7.50	
Fernandez, F. M. (dec.), Miami.....		10.00
Foxworthy, F. W., Miami Beach.....	7.50	
Kemp, Austin J. (dec.), Miami.....	7.50	
Matthieu, Joseph, New York, N. Y....	7.50	
Moore, T. Earl, Topeka, Kans.....	7.50*	
Reiss, George L., Miami Beach.....	7.50*	
DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY:		
Pyatt, W. S., Bowling Green	7.50	
DUVAL COUNTY MEDICAL SOCIETY:		
McDaniel, R. L., Jacksonville.....	7.50	
Martin, P. H., Memphis, Tenn.....	7.50	
O'Dell, John, C., Jacksonville.....	7.50	...*
ESCAMBIA COUNTY MEDICAL SOCIETY:		
Blackshear, T. E., Pensacola	7.50	
Thames, J. G., Milton	7.50	
HILLSBOROUGH COUNTY MEDICAL SOCIETY:		
Faver, H. M., Tampa	7.50	
INDIVIDUALS:		
Coupland, James D., Orlando	7.50	
Sayre, Robert F., St. Petersburg.....	7.50	
JACKSON COUNTY MEDICAL SOCIETY:		
Pierce, Lewis, Marianna	7.50*	
Hodges, G. S. (dec.), Marianna	7.50	
MARION COUNTY MEDICAL SOCIETY:		
Futch, Thos. A., Jr., Ocala.....		10.00
PALM BEACH COUNTY MEDICAL SOCIETY:		
Buck, William J., Belle Glade.....	7.50	
Cason, John R. (dec.), Delray Beach..	7.50	
Webb, Roy, Delray Beach	7.50	



Name and Address	Dues Not Paid 1936	1937
PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY:		
Bourke, John J., Albany, N. Y.		10.00
Cannon, Augustus B., Lacoochee		10.00
Dame, Leland H., W. Palm Beach		10.00
PINELLAS COUNTY MEDICAL SOCIETY:		
Smiseth, S. P., Sutton's Bay, Mich.		10.00
ST. JOHNS COUNTY MEDICAL SOCIETY:		
Bennett, John L., St. Augustine	7.50	
ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY:		
Claxton, W. A. (dec.), Oteen, N. C.	7.50	
Davis, Claude L., Alma, Ga.	7.50	
	$180.00	$ 60.00
Dues of Secretaries		310.00
		370.00
		180.00
Total		$550.00

* Reinstated.

ASSETS AND LIABILITIES
March 22, 1937

Assets	
Cash in Bank	$10,147.78
General Fund—Accounts Receivable	2,660.00
Furniture and Fixtures (less depreciation)	340.88
Library	486.25
Stationery Inventory	140.14
Savings: Atlantic National Bank	4,100.82
Barnett National Bank	8,462.76
Investment (Treasury Bonds)	10,178.13
	$36,516.76
Liabilities	
Journal—Accounts Receivable	62.00
Capital Account	36,454.76
	$36,516.76

Upon motion by Dr. L. M. Anderson, seconded by Dr. J. W. Snyder, the Association voted unanimously to accept the above report as read.

Dr. Feaster then called for the report of the Executive Committee, which was read by Dr. G. S. Osincup, as follows:

REPORT OF EXECUTIVE COMMITTEE

To the President and Members of the Florida Medical Association in Session at St. Petersburg, April 6, 1937:

Five meetings of the Executive Committee were held during the fiscal year and a number of matters passed upon by the members through correspondence.

The first meeting was held April 29, 1936, in the dining room of the SS. Florida and Dr. Gilbert S. Osincup was unanimously elected chairman of the committee. Dr. Edward Jelks resigned as a member of the Executive Committee, owing to his election to the office of president-elect. Doctor Jelks' resignation was accepted and President Feaster appointed Dr. E. T. Sellers to fill the unexpired term.

Stewart G. Thompson was appointed business manager for the ensuing year by unanimous vote. A working budget for the ensuing year was presented and read item by item and the budget approved as a working basis for the Association's central office.

On July 3, a request was received from the Pinellas County Medical Society that the official dates of the sixty-fourth annual convention of the Association, to be held at St. Petersburg, be designated as April 5, 6, and 7, 1937. A letter was dispatched to each member of the Executive Committee and the dates as suggested by the Pinellas County Medical Society were approved.

A request was presented by the Medical Economics Committee that a questionnaire be mailed to the secretaries of all component societies. On September 17, 1936, the members of the Executive Committee by letter approved the questionnaire which was mailed out on October 1, 1936, through the business office.

A fully equipped addressograph with embosser and name plates was authorized by the committee to be purchased by the business office, at a cost of $419.20. This addressograph will be a very valuable part of the regular equipment of the Association, as the Journals are mailed each month from the business office and circulars and other material mailed out from the official list of the membership as shown on the name plates. Heretofore, an addressograph was borrowed for this purpose but the work has so increased that the Executive Committee felt it opportune to make this a permanent part of the Association's equipment.

On January 17, 1937, the Executive Committee met in Jacksonville at the time of the pre-convention meeting. A communication was received from the Aetna Casualty and Surety Company, advising of an increase in rates. The rate for 5/15,000 limits was increased from $20.00 to $22.50. No action was taken by the Committee as the rate went into effect December 1, 1936.

A complaint was received from Dr. H. E. Winchester of Dunedin against the United States Fidelity & Guaranty Company. Doctor Winchester reported that a settlement of $150.00 had been made by the company without his consent. The secretary, Doctor Richardson, and the legal advisor, Mr. Sam Marks, were instructed to investigate the complaint and write a letter to the insurance company, and that a copy of the letter be mailed to Doctor Winchester. On January 20, 1937, Doctor Richardson, the secretary of the Association, addressed a communication which was prepared by Mr. Sam Marks, the legal advisor, to the United States Fidelity & Guaranty Company at Baltimore, Maryland, outlining the report from Doctor Winchester and included the following:

> "In view of the conditions of the master policy specifying that 'no claim covered by this policy shall be settled or compromised by the company except with the consent of the assured against whom claim is made, and the written consent of a majority of the committee of five members of this group,' it would seem that this claim was recognized and paid contrary to the wishes of Doctor Winchester and in violation of the policy provisions."

On February 6, 1937, a letter was received from the United States Fidelity & Guaranty Company which read in part:

> "We regret exceedingly that you were misinformed concerning our handling of this claim and can readily appreciate that Doctor Winchester would wonder why we made payment on a claim against him, contrary to his request. You will please inform Doctor Winchester that we did not do so."

A complete copy of the letter from the United States Fidelity & Guaranty Company, dated February 6, 1937, was mailed to Doctor Winchester.

Owing to certain changes necessitated by the change of the By-Laws at the last annual meeting, the question of a schedule of program for annual conventions was discussed at length. The schedule followed at this meeting was passed.

Your Committee took action allowing a fifty per cent commission to the entertaining society for local advertisements that they might sell for the convention number of the Journal as an aid in meeting expenses of entertainment during the annual meeting, such advertisements to be sold

to local concerns in the convention city and all sales to be subject to the approval of the secretary or business manager of the Association.

The official statement of proposed expense in connection with the reopening of the case of S. V. Sbordi was presented by the officers of the Pinellas County Medical Society and, on motion, the request for $200.00 to match an equal amount put up by the Pinellas County Society, was granted. The application and statement were prepared in accordance with the provisions in the By-Laws.

On March 21, 1937, your committee met at Orlando at the request of President Feaster and the officers of the Association were invited to attend this meeting. The purpose of the meeting was to consider the feasibility of the adoption of the recommendations in retiring President Bryans' address in accordance with action taken by the House of Delegates at its meeting last year.

The first recommendation proposed in the retiring president's address was to consider the advisability of employing a full-time managing director and report the recommendation to the next annual meeting. A report was prepared, giving an outline of the plan for a full-time managing director, with a budget set-up to cover operating expenses and an analysis of the possibility of financing. By a unanimous vote, it was approved and decided to mimeograph the report and transmit it to the delegates for their perusal. The thought of the committee and officers present was that each delegate should be familiar with all the details in connection therewith, in order that he might be able to vote intelligently at the meeting of the House of Delegates in St. Petersburg. By unanimous action, it was also decided to present a resolution at the meeting of the House of Delegates which was passed last night.

At meetings held during the convention, two resolutions were approved by your committee for presentation at the meeting of the House of Delegates; one in connection with communities or large cities in the State in which compulsory health examinations are required in cases of food handlers, barbers, and other employees, and that such examinations are not recognized by city health authorities if made by members of the component medical societies other than those employed by the health departments; and the other relative to institutions in the State securing services of practitioners not in sympathy with the standards of this Association for purposes of instructing certain groups. The text of these resolutions and action taken will be shown in the proceedings of the meeting of the House of Delegates.

Respectfully submitted,
GILBERT S. OSINCUP, Chairman;
WILLIAM M. DAVIS,
ROY J. HOLMES,
HENRY E. PALMER,
E. T. SELLERS,
WILLIAM C. THOMAS,
ORION O. FEASTER,
SHALER RICHARDSON.

It was moved and seconded that the above report be accepted as read. Unanimously carried.

Dr. Feaster read the following resolution, which was accepted:

"*Whereas,* Dr. Gordon Ira has served as Chairman of the Advisory Board to the Woman's State Auxiliary for the past three years, and

"*Whereas,* by his untiring interest and wise counsel, he has rendered the said organization untold service,

"THEREFORE, BE IT RESOLVED, that the Woman's Auxiliary in general meeting assembled, April 6, 1937, extend to Dr. Ira its heartfelt thanks and sincere appreciation. And further order that a copy of this resolution be spread upon the minutes of this organization.

"(Signed) MRS. E. R. MCMURRAY,
MRS. O. O. FEASTER,
MRS. R. D. FERGUSON."

Dr. M. Jay Flipse, as First Vice-President, took over the Chair and introduced Dr. O. O. Feaster of St. Petersburg who read his Presidential Address.

Dr. Feaster then resumed the Chair.

Dr. J. H. J. Upham of Columbus, Ohio, President-elect of the American Medical Association, was introduced by Dr. Feaster. Dr. Upham delivered an address on "Heart Disease in Middle Life," illustrated with lantern slides.

The Guest Speaker, Dr. Morris Fishbein of Chicago, Editor of the Journal of the American Medical Association and of Hygeia, was then introduced by Dr. Feaster. Dr. Fishbein delivered an address on "The Nature of Medical Organization."

THIRD SCIENTIFIC ASSEMBLY

The Scientific Assembly reconvened at 2:00 p. m., Tuesday, April 6, with Dr. L. M. Anderson presiding.

The following papers were read and discussed:

9. "Use and Abuse of the X-ray in the Treatment of Skin Diseases," Dr. Wiley M. Sams, Miami.

10. "Carcinoma of the Body of the Uterus," Dr. Cayetano Panettiere, Miami Beach.
11. "Traumatic Surgery," Dr. Lloyd J. Netto, West Palm Beach.
12. "Gonorrheal Arthritis," Drs. Arthur H. Weiland and Charles R. Burbacher, Coral Gables. (Read by Dr. Weiland.)
13. "Reaction Following Application of X-ray Therapy" (colored motion pictures, lantern slides), Dr. H. Bernard McEuen, Jacksonville.

MEETING OF THE HOUSE OF DELEGATES
SECOND SESSION

The second session of the House of Delegates convened at 5:00 p. m., Tuesday, April 6, in the East End of Ball Room of the Vinoy Park Hotel; Dr. O. O. Feaster in the Chair.

The following delegates answered roll-call:

DELEGATES

Alachua County Medical Society:
J. E. Maines, Jr.

Bay County Medical Society:
W. C. Roberts

Brevard County Medical Society:
T. C. Kenaston

Broward County Medical Society:
Leigh F. Robinson

Columbia County Medical Society:
L. M. Anderson

Dade County Medical Society:
M. J. Flipse
Homer Pearson
H. A. Barge
R. N. Burch
Edgar Peters
H. A. Walker
Joseph Stewart

Duval County Medical Society:
L. Y. Dyrenforth
Edward Jelks
Ferdinand Richards
E. T. Sellers
C. D. Rollins

Escambia County Medical Society:
J. M. Hoffman
H. L. Bryans

Hillsborough County Medical Society:
J. C. Dickinson
George L. Cook

Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society:
J. C. Robertson
B. A. Wilkinson

Manatee County Medical Society:
S. G. Hollingsworth

Marion County Medical Society:
R. D. Ferguson

Orange County Medical Society:
W. H. Spiers
J. S. McEwan
H. A. Day

Palm Beach County Medical Society:
F. K. Herpel
W. L. Shackelford

Pinellas County Medical Society:
A. J. Wood

Polk County Medical Society:
R. L. Cline

Putnam County Medical Society:
W. J. Williams

St. Johns County Medical Society:
Reddin Britt

Seminole County Medical Society:
J. W. Martin

Volusia County Medical Society:
J. Ralston Wells
J. E. Taylor

DeSoto-Hardee-Highlands, Jackson, Lake, Lee, Madison, Monroe, Pasco-Hernando-Citrus, St. Lucie-Okeechobee-Indian River-Martin, Sarasota, Sumter, Taylor and Walton-Okaloosa County Medical Societies were not represented.

A motion to seat Dr. S. G. Hollingsworth in place of Dr. Hubbard Gates for Manatee County, carried.

Dr. J. S. McEwan offered a motion that the House of Delegates reconsider the passing of the amendments to the Constitution acted upon the previous day. The motion was carried to reconsider the amendments to the Constitution as passed at the First session of the House of Delegates on Monday evening.

The proposed amendment to Article XI of the Constitution was read by the Secretary, as follows:

"Article XI shall be amended to read as follows: 'Any article of the Constitution may be amended by two-thirds vote of the Delegates registered at that Annual Meeting and referred to the component county societies for ratification during the ensuing year; each society ratifying by majority vote of its members present at any regular meeting; it being necessary for three-fourths of the component societies to vote in favor of its ratification during the year.'"

Dr. J. S. McEwan, Dr. F. K. Herpel and Dr. M. Jay Flipse discussed the proposed amendment and the vote to reconsider was put before the House. The motion was lost.

The Secretary then read the proposed amendment to Section 3, Article VII, of the Constitution relative to the election of officers, as follows:

"Section 3, Article VII of the Constitution relative to election of officers, shall be amended to read as follows: 'The officers of this Association shall be elected by the House of Delegates at its last regular session of the Annual Meeting, and referred to the last General Session for confirmation; and any member shall be eligible to any office named in Section 1 of Article VII of the Constitution, but no person shall be elected to such an office who is not in attendance during that Annual Meeting (except the Secretary, Treasurer, and the Editor of the Journal) and who has not been a member of the Association for five years.'"

Dr. Homer Pearson then moved for reconsideration of this amendment and it was duly seconded and carried.

Dr. H. A. Day moved the adoption of the amendment as read and the motion was seconded.

Drs. L. M. Anderson, R. L. Cline, J. Ralston Wells and H. A. Walker discussed the amendment briefly, giving their reasons for not favoring the proposed change. Dr. H. C. Dozier, a past-president, was accorded the privilege of the floor, and spoke against the amendment.

The question was put to the House and the motion to adopt the amendment was lost.

The amendments to the By-Laws as introduced at the first session of the House of Delegates were then taken up and Dr. M. Jay Flipse moved that the amendments be voted on item by item. The motion was duly seconded and carried.

Dr. Leigh F. Robinson, who read the proposed amendments explained the meaning before each vote was taken.

Dr. Robinson read the following proposed amendment:

Chapter VII of the By-Laws shall be amended as follows:

The first paragraph of Section 1 shall read: Regular committees shall be the Executive Committee (or may be called the Board of Governors) (Section 2); a Committee on Scientific Work (Section 3); a Committee on Legislation and Public Policy (Section 4); a Committee on Publication (Section 5); a Committee on Medical Education and Hospitals (Section 6); a Committee on Public Relations (Section 7); a Committee on Necrology (Section 8); a Committee on Medical Post-Graduate Course (Section 9); a Committee on Cancer Control (Section 10); a Committee on Medical Economics (Section 11); an Inter-relationship Committee (to work with similar committees from allied professions — dentists, druggists and nurses) (Section 12); a Committee on Tuberculosis and Public Health (Section 13); a Committee on State Controlled Medical Institutions (Florida State Hospital and Florida Farm Colony) (Section 14); a Committee on Maternal Welfare (Section 15); a Committee on Child Health (Section 16); an Advisory Committee to the Woman's Auxiliary (Section 17); a Committee as Representatives to the Industrial Council (Section 18); a Committee on Venereal Disease Control (Section 19). They shall be appointed by the President as hereinafter prescribed. The Committee on Arrangements shall consist of the component society where the annual meeting of the Association is to be held (Section 20).

It was moved and seconded that the amendment be adopted. Voted and carried.

Dr. Robinson read the following proposed amendment to the By-Laws:

The Section numbers of Chapter VII shall be changed as follows: Section 6 shall be 20; Section 7 shall be 6; Section 8 shall be 7; Section 9 shall be 8; Section 10 shall be 9; Section 11 shall be 10; Section 12 shall be 11; Section 13 shall be 12; Section 14 shall be 13; Section 15 shall be 14; Section 16 shall be 15.

It was moved and seconded that the amendment be adopted. Voted and carried.

Dr. Robinson then read the following proposed amendment:

Section 15 shall be amended to include this clause: This Committee shall hold joint meetings with the Committee on Child Health and the two, jointly, shall function as the Committee on Maternal Welfare and Child Health. The chairman of this committee shall be chairman of the joint committee. Section 16 shall provide for a Committee on Child Health: The Committee on Child Health shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years and two for three years, and thereafter they shall be appointed for three years, as the terms expire. The chairman of this committee shall be appointed by the President. The duties of this committee shall be such as usually fall upon such a committee. This committee shall hold joint meetings with the Committee on Maternal Welfare, and the two, jointly, shall function as the Committee on Maternal Welfare and Child Health. The chairman of the Maternal Welfare Committee shall be chairman of the joint committee.

It was moved and seconded that the amendment be adopted. Voted and carried.

The following proposed amendment was then read by Dr. Robinson:

Section 18 shall be added to include a Committee as Representatives to the Industrial Council: The Committee as Representatives to the Industrial Council shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years and two for three years and thereafter they shall be appointed for three years as the terms expire. The chairman of this Committee shall be selected by the President. The duties of this Committee shall be to represent the Florida Medical Association at meetings of the Industrial Council.

It was moved and seconded that the amendment be adopted. Voted and carried.

Dr. Robinson read the following proposed amendment and moved that it be adopted:

Section 19 shall be added to include the Committee on Venereal Disease Control: This Committee shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years and two for three years and thereafter they shall be appointed for three years as the terms expire. The chairman of this Committee shall be selected by the President. The duties of this Committee shall be such as usually fall upon such a committee.

The motion was seconded that the amendment be adopted. Voted and carried.

The following proposed amendment was read by Dr. Robinson:

The number of the Section pertaining to reports of committees to the House of Delegates shall be changed from 18 to 21.

It was moved and seconded that the amendment be adopted. Voted and carried.

Dr. Robinson then read the following proposed amendment:

Sections 2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, and 17 of Chapter VII of the By-Laws shall be amended by deleting the clause, "This Committee shall meet immediately after the adjournment of the annual meeting and elect its chairman" and inserting in lieu thereof, "The President shall select the chairman of this Committee."

It was moved and seconded that the amendment be adopted. Voted and carried.

The following proposed amendment was read by Dr. Robinson:

Section 2 of Chapter VII of the By-Laws shall be amended to include the following addition: Invitations for the next annual meeting of the Florida Medical Association shall be presented to the Executive Committee (or Board of Governors) prior to or at the pre-convention meeting. This Committee shall investigate the facilities for entertaining the Association and the feasibility of holding the annual meeting in such places, and recommend the place most desirable, at that time, to the House of Delegates at its first regular meeting, for approval. In the event there is no invitation, the Executive Committee shall recommend the place most desirable.

It was moved and seconded that the amendment be adopted. Voted and carried.

Dr. Robinson then read the following proposed amendment:

Section 15 of Chapter III shall be amended to include the following addition: Upon recommendation of the Executive Committee.

It was moved and seconded that the amendment be adopted. Voted and carried.

The following proposed amendment was then read by Dr. Robinson:

The second paragraph of Section 1, Chapter VI of the By-Laws shall be amended by deleting the clause, "The councilors shall meet immediately after the adjournment of the annual meeting and elect their chairman and a secretary and the latter shall keep a record of the proceedings" and inserting in lieu thereof, "The President shall select the chairman of the Council."

It was moved and seconded that the amendment be adopted. Voted and carried.

The following resolution which was referred back to the Committee for revision at the first session of the House of Delegates was read by Dr. Edward Jelks:

"*Whereas,* It has been brought to the attention of the Florida Medical Association that certain institutions in the State have been securing the services of practitioners not doctors of medicine, dentists, pharmacists or nurses, for purposes of instructing certain groups; and

"*Whereas,* certain institutions in the State, in organizing their staffs for the care of the sick, have availed themselves of the services of such practitioners;

"THEREFORE, BE IT RESOLVED, that this body go on record as being opposed to the appearance of its members on programs where instruction is given on medical subjects, or serving on staffs of institutions engaged in the diagnosis of disease and care of the sick, in association with the above mentioned practitioners."

Dr. Jelks moved that the resolution be adopted. Dr. H. A. Walker seconded the motion.

Dr. M. J. Flipse moved to amend this motion to state that a special committee be appointed to bear this resolution in person to such institutions as are known to have violated in the past this particular idea and that this resolution be presented together with explanatory remarks to the institutions.

The motion was duly seconded and carried and the amendment to the resolution was adopted.

The vote was put on the resolution as amended, and carried and the resolution as amended was adopted.

Dr. W. H. Spiers moved that the Committee on Medical Post-Graduate Course be appointed to convey the resolution to the institutions. Dr. J. E. Maines seconded the motion. After discussion, Dr. Spiers, with consent of his second, withdrew his motion.

There being no further business, the meeting adjourned.

FOURTH SCIENTIFIC ASSEMBLY

The Fourth Scientific Assembly was held Wednesday, April 7, 9:00 a. m., Dr. Leigh F. Robinson, presiding.

The following papers were read and discussed:

14. "A Simplified Method of Treating Fractures of the Shaft of the Humerus" (lantern slides), Dr. Charles B. Mabry, Jacksonville.
15. "Deafness from Drugs," Dr. H. Marshall Taylor, Jacksonville.
16. "Recent Advances in the Diagnosis and Treatment of Asthma," Dr. J. Ralph Vallotton, Daytona Beach.
17. "The Use of X-Radiation in Conditions Other Than Malignancy," Dr. Gerard Raap, Miami.
18. "Surgery of the Ureter" (motion pictures, lantern slides), Dr. Robert B. McIver, Jacksonville.
19. "Hypoglycemic Shock Therapy in Dementia Praecox," Dr. H. Mason Smith, Tampa.

THIRD GENERAL SESSION

The General Session of the Florida Medical Association reconvened at 12:00 noon, April 7, in the Ball Room of the Vinoy Park Hotel, with President O. O. Feaster in the Chair.

There being no new business, the election of officers was taken up. President Feaster called for nominations for President-elect.

Dr. W. H. Spiers of Orlando was nominated by Dr. H. A. Walker. Nomination seconded by Dr. L. M. Anderson and endorsed by Drs. H. E. Palmer and R. B. Harkness. Motion by Dr. E. G. Peek that the nominations be closed and the Secretary instructed to cast the unanimous ballot of this Association for Dr. Spiers. Motion

seconded by Dr. H. L. Bryans, voted and unanimously carried.

Dr. Spiers: "I know you have not done this because of any unusual ability on my part but because of a certain friendly feeling and, therefore, I feel that I have your cooperation and I certainly will need that help."

Dr. Norval M. Marr of St. Petersburg was nominated for First Vice-President by Dr. E. G. Peek. Nomination seconded by Dr. W. M. Rowlett. Motion by Dr. H. A. Barge that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Marr. Seconded. Voted and carried.

Dr. R. N. Burch of Miami was nominated for Second Vice-President by Dr. H. A. Barge. Seconded by Dr. J. C. Davis. Motion by Dr. Davis that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Burch. Voted and carried.

Dr. George L. Cook of Tampa was nominated for Third Vice-President by Dr. W. M. Rowlett. Seconded by Dr. L. M. Anderson. Motion by Dr. Anderson that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Cook. Voted and carried.

Dr. Shaler Richardson of Jacksonville was nominated by Dr. C. D. Christ for Secretary-Treasurer of the Association and Editor of the Journal. Seconded by Dr. W. M. Rowlett. Motion by Dr. L. M. Anderson that the nominations be closed and that a unanimous ballot be cast for Dr. Richardson. Voted and carried.

Dr. Richardson: "Gentlemen, I appreciate the honor you have conferred upon me. Dr. Feaster says I have dodged the talking this year. We have had such a splendid presiding officer in Dr. Feaster that I have remained in silence while admiring the way he has handled the meetings. I assure you it is a pleasure to serve you again. Twelve years ago in St. Petersburg, I was elected secretary-treasurer and I certainly appreciate the confidence the Association has had in my efforts."

Dr. Feaster then called on Dr. R. H. Knowlton, Chairman of the Golf Committee, who presented prizes to the following doctors:

First prize: Orlando Cup (low net score)—Dr. J. R. Chandler, Daytona Beach. Drs. C. E. Dunaway and A. H. Weiland tied with Dr. Chandler for this prize but being ineligible for more than one prize, the cup was awarded to Dr. Chandler.

Second prize: Runner-up (2nd low net score) Pinellas Cup—Dr. W. H. McCullagh, Jacksonville.

Third prize: (Low gross medal score)—Drs. C. E. Dunaway, Miami; A. H. Weiland, Miami; and C. A. Rudisill, Tampa, tied. On the draw, Dr. Rudisill received the physician's bag, donated by Mr. Henry Parramore, president of the Surgical Supply Company; Dr. Dunaway received the black golf bag, donated by the American Optical Company; and Dr. Weiland received the sterilizer, donated by the Miami Surgical Company.

Fourth prize: (Blind Bogey)—Drs. R. P. Henderson, Orlando, and R. R. Duke, Tampa, tied. On the draw, Dr. Henderson received the brown golf bag.

Dr. Feaster: "I would like to express my appreciation of the close and kindly cooperation of the other officers of the Association, the various committeemen and the members generally. It has been my privilege to visit a number of county societies during the past year. I was always received with unfailing courtesy and every consideration was shown me. I bespeak to my successor, Edward Jelks, the same cooperation that you have given me. I will ask Dr. J. C. Davis of Quincy and Dr. John S. McEwan of Orlando to escort the new President to the Chair. Dr. Jelks, I want to congratulate you and wish you every success. If there is ever anything I can do, you have only to call on me."

Dr. Jelks: "Fellow Members of the Florida Medical Association, you are not going to be inflicted with a speech. I promise you I will have one next year so you can save up all your listening until that time.

"When this honor was afforded me last year, I was at a loss to know just how to begin thinking about what attitude I could take through which I could be of most service to our organization. Dr. Feaster has just said that he thinks any man tries to figure out something he can do; something he can accomplish for the organization. I think that the attitude that I assume from the beginning will largely direct the success of the administration. I ran across a quotation from one of our predecessors, a man who lived in Bagdad in about the last of the ninth century. He was a Bagdadian who had done a great deal in correlating and filing what was known of Greek and Arabic medicine. His name was Rhazes. He was the first man to describe ade-

quately the two diseases of measles and smallpox. How many books he wrote, the records have not been able to account for. He wrote a book on the subject of therapy that six hundred years later was translated as a textbook. He must have had a very fine outlook on life and I know that to be the attitude I am going to take the next year. He says it is impossible to see all, to test everything oneself and that the knowledge, the experience of a single individual compared with the knowledge and the experience of all men resembles a thin thread of water placed beside a great river. With that attitude and realizing the limitations of one man, I deem it a great honor and a great pleasure to assume the responsibility of trying to follow your lead the next year."

President Jelks called on Dr. L. M. Anderson to present the Past-President's button to Dr. Feaster.

Dr. Anderson: "Mr. President, Members of the Florida Medical Association and Guests, this is a pleasure that I have enjoyed several times. Dr. Feaster, you are standing before us recognized as the head of the Florida Medical Association and there is none greater. There is one complaint that I want to make; I don't see enough of these past-president's buttons at the meeting. I want you next year to display this button so that we will know how you stand.

"For your fair ruling on problems and helpful work that you have done for your Association, we take great pleasure in pinning this button on you and hope that you will wear it the rest of the time. Don't let me come to the next medical meeting as I have done for the past forty years and see you, Dr. Feaster, without this button.

"We appreciate the courtesies you have shown the members of the Florida Medical Association and your valuable accomplishments and under you, I think we have made progress and I hope that under our incoming President, we will make still more."

Dr. Jelks: "We all realize that this is one of the outstanding meetings in the history of the Association. Some of us have warned the men in Miami that they will have to stir about if they want to keep up with the men in St. Petersburg."

Dr. E. G. Peek: "I move this organization cast a standing vote of thanks to the Pinellas County Medical Society."

Dr. H. A. Day seconded Dr. Peek's motion and a standing vote of thanks was given the Pinellas County Society.

There being no further business to come before the meeting, on motion, duly seconded and carried, the meeting adjourned, *sine die*.

The Travelogue: Moving pictures taken on the Convention Cruise to and in Cuba were shown by Dr. Herbert L. Bryans, Pensacola.

REGISTRATION

The total registration during the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, was 658; members, 361; visitors, 77; exhibitors, 54; Woman's Auxiliary, 166.

REGISTRATION

Officers

FEASTER, ORION OTIS, President St. Petersburg
JELKS, EDWARD, President-elect Jacksonville
FLIPSE, M. JAY, First Vice-President Miami
SPIERS, WILLIAM H., Second Vice-President Orlando
RICHARDSON, SHALER, Secretary-Treasurer Jacksonville
THOMPSON, STEWART, Business Manager Jacksonville

Alachua County Medical Society

Anderson, James M. Cross City
Andrews, Edwin H. Gainesville
Cobb, Alva Thomas, Jr. Gainesville
Dailey, I. A. Micanopy
Dell, J. Maxey Gainesville
Maines, John E., Sr. Lake Butler
Maines, John E., Jr. Gainesville
Snow, Thomas A. Gainesville
Summerlin, J. L. Gainesville
Thomas, W. C. Gainesville
Tillman, George C. Gainesville
Young, Wm. C. Chiefland

Bay County Medical Society

Roberts, William C. Panama City
Whitfield, J. M. Panama City

Brevard County Medical Society

Bean, I. F. Melbourne
Kenaston, T. C. Cocoa
Page, Walter C. Cocoa

Broward County Medical Society

Brunson, Francis A. Hollywood
Hendricks, Elliott M. Ft. Lauderdale
Peavy, Henry J. Ft. Lauderdale
Robinson, Leigh F. Ft. Lauderdale
Shell, Paul G. Ft. Lauderdale

Columbia County Medical Society

Anderson, L. M. Lake City
Bates, Thomas H. Lake City
Harkness, Robert B. Lake City

Dade County Medical Society

Barge, H. A. Miami
Barge, W. J. Miami
Burch, R. N. Miami
Davis, H. Frank Miami
Dunaway, Carl E. Miami
French, Elmo D. Miami
Hall, John E. Miami
Hodsdon, Benjamin F. Miami
Holmes, Roy J. Miami

Jones, Walter C., Jr. Miami
Kennon, Charles L. Miami
Lefholz, R. Miami
Leonard, George N. Miami Beach
McClamroch, James M. Miami
McKenzie, E. N. Miami
McKibben, William W. Miami
Morrow, Frank R. Miami
Nugent, James J. Miami
Owens, Duncan Miami Beach
Panettiere, Cayetano Miami Beach
Payton, Frazier J. Miami Beach
Pearson, Homer L., Jr. Miami
Perdue, Jean Miami Beach
Perry, C. Larimore Miami
Peters, Edgar Miami
Pintado, Nilo C. Miami
Quillian, Warren Coral Gables
Raap, Gerard Miami
Rentz, L. S. Coconut Grove
Sams, Wiley M. Miami
Snyder, John W. Miami
Stewart, J. S. Miami
Tumlin, Corbett E. Miami
Walker, Harrison A. Miami Beach
Weiland, A. H. Coral Gables
Welch, P. B. Miami
Wilson, M. C. Miami
Youmans, Corren P. St. Petersburg

DeSoto-Hardee-Highlands County Medical Society

Chandler, Isaac Wayne Avon Park
Kirkpatrick, Charles H. Arcadia
Martin, Leldon W. Sebring
Poucher, Allen A. Wauchula

Duval County Medical Society

Black, J. B. Jacksonville
Boone, James L. Jacksonville
Borland, J. L. Jacksonville
Brown, Alan D. Jacksonville
Bryant, James M. Jacksonville
Cason, Turner Z. Jacksonville
Chapman, Benjamin A. Jacksonville
Dyrenforth, Lucien Y. Jacksonville
Gammon, Julian E. Jacksonville
Hanson, Karl B. Jacksonville
Hayes, J. W. Jacksonville
Holden, Gerry R. Jacksonville
Holloway, Luther W. Jacksonville
Ira, Gordon H. Jacksonville
Kirby-Smith, Joseph L. Jacksonville
Limbaugh, Louie M. Jacksonville
Lipscomb, T. H. Jacksonville
Lyerly, J. G. Jacksonville
McCreary, A. B. Jacksonville
McCullagh, William H. Jacksonville
McEuen, H. Bernard Jacksonville
McIver, Robert B. Jacksonville
McPhaul, W. A. Jacksonville
Mabry, C. B. Jacksonville
Manning, William S. Jacksonville
Morris, Kenneth A. Jacksonville
O'Dell, John C., Jr. Jacksonville
Oetjen, G. F. Jacksonville
Richards, Ferdinand Jacksonville
Rollins, Clarence D. So. Jacksonville
Ross, William E. Jacksonville
Royce, Clayton E. Jacksonville
Sellers, E. T. Jacksonville
Shaw, W. M. Jacksonville
Sompayrac, Lauren M. Jacksonville
Swift, Edwin C. Jacksonville
Taylor, H. Marshall Jacksonville
Van Schaick, Harold D. Jacksonville
Waas, F. J. Jacksonville
Wilson, Alpheus K. Jacksonville

Escambia County Medical Society

Bryans, H. L. Pensacola
Hoffman, James M. Pensacola
Lischkoff, M. A. Pensacola
McLane, J. N. Pensacola
Pickett, W. H. Pensacola
Turberville, J. I. Century
Turberville, J. S. Century

Hillsborough County Medical Society

Adamson, William P. Tampa
Andrews, Chadbourne A. Tampa
Beyer, A. R. Tampa
Bidwell, A. M. Tampa
Blackmon, H. J. Tampa
Blake, W. C. Tampa
Boling, John R. Tampa
Brown, H. O. Tampa
Carlton, Leland F. Tampa
Carter, E. F. Tampa
Chandler, J. C. Tampa
Cook, George L. Tampa
Cook, H. M. Tampa
Cowart, James T. Tampa
Dickinson, Joshua C. Tampa
Duncan, William P. Tampa
Ely, R. A. Tampa
Estes, J. L. Tampa
Etheredge, S. H. Tampa
Gilbert, Elsie Tampa
Gilmer, Eugene S. Tampa
Guerra, Julio J. Tampa
Gyland, Stephen P. Tampa
Jobson, A. M. C. Tampa
Knauf, A. R. Tampa
Lancaster, William J. Wilmington, N. C.
Lowry, Blackburn W. Tampa
McEachern, J. R. Tampa
Maguire, Thomas C. Plant City
Maner, George R. Tampa
Marcus, Nathan L. Tampa
Martin, Douglas D. Tampa
Nelson, Robert G. Tampa
Pate, Julien C. Tampa
Rowlett, W. M. Tampa
Smith, Burdette Tampa
Smith, H. Mason Tampa
Smoak, Edward Tampa
Snow, H. O. Tampa
Spengler, Nathaniel L. Tampa
Spoto, Joseph S. Tampa
Stringer, Sheldon Tampa
Torbett, R. S. Tampa
Vinson, J. C. Tampa
Whitaker, Harper E. Tampa

Lake County Medical Society

Ashton, Wilbur L. Umatilla
Coleman, E. M. Clermont
Oetjen, Leroy H. Leesburg

Lee County Medical Society

Bostelman, Ernest Ft. Myers
Jones, H. Quillian Ft. Myers
Stipe, Harvie J. Ft. Myers

Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

Davis, Julius C. Quincy
Gainey, J. G. Blountstown
Johnston, John K. Tallahassee
Logie, Arthur J. Jacksonville
Miles, W. G. Chattahoochee
Moor, F. Clifton Tallahassee
Palmer, Henry E. Tallahassee
Pound, J. H. Tallahassee
Rhodes, Bricey M. Tallahassee
Robertson, J. C. Chattahoochee

White, Sarah P. Tallahassee
Wilkinson, B. A. Tallahassee
Williams, John L. Tallahassee

Manatee County Medical Society

Gates, Hubbard Bradenton
Harrison, M. M. Bradenton
Hollingsworth, S. G. Bradenton
Lancaster, B. M. Manatee
Larrabee, Charles W. Bradenton
McDuffee, Toliver M. Manatee
Mason, John F. Bradenton
Sugg, William D. Bradenton

Marion County Medical Society

Dozier, Henry C. Ocala
Ferguson, R. D. Ocala
Freeman, Albert H. Ocala
Lindner, E. G. Ocala
Lytle, Carl S. Dunnellon
Peek, Eugene G. Ocala
Russell, Ralph E. Ocala
Watt, Harry F. Ocala

Orange County Medical Society

Andrews, Mitchell M. Orlando
Brame, Dorothy D. Orlando
Christ, Calvin D. Orlando
Collins, Charles J. Orlando
Day, Horace A. Orlando
Gwathmey, G. Tayloe Orlando
Harms, F. H. Orlando
Hart, Ruth S. Winter Park
Henderson, R. P. Orlando
Ingram, L. C. Orlando
Jewett, Eugene L. Orlando
Johnston, Hewitt Orlando
McEwan, John S. Orlando
Mallory, Meredith Orlando
Orr, Louis M., Jr. Orlando
Osincup, Gilbert S. Orlando
Page, W. Grady Orlando
Pines, John A. Orlando
Redding, John L. Orlando
Rivers, Thomas M. Kissimmee
Shoemaker, Samuel A. Orlando
Sinclair, W. E. Orlando
Sutter, Leroy M. Orlando

Palm Beach County Medical Society

Arnold, Wilbur O. West Palm Beach
Dawson, George M. West Palm Beach
Heath, Guy W. West Palm Beach
Herpel, Frederick K. West Palm Beach
Netto, Lloyd J. West Palm Beach
Rozier, Lauchlin M. West Palm Beach
Shackelford, W. L. West Palm Beach
Sory, B. B., Jr. Palm Beach
Sory, James R. Lake Worth

Pasco-Hernando-Citrus County Medical Society

Creekmore, George R. Brooksville
Harvard, S. C. Brooksville
Walters, William H., Jr. Lacoochee

Pinellas County Medical Society

Anderson, Arnold S. St. Petersburg
Anderson, C. O. St. Petersburg
Anderson, J. M. St. Petersburg
Bieker, Annette M. St. Petersburg
Bieker, Arthur J., Jr. St. Petersburg
Black, M. Eldridge Clearwater
Center, R. H. Clearwater
Cooper, John H. St. Petersburg
Davis, W. M. St. Petersburg
Dawson, S. A. St. Petersburg
Dickerson, Lucien B. Clearwater
Dicks, Reid E. St. Petersburg
Echard, T. B. St. Petersburg
Farber, C. K. St. Petersburg
Farber, William P. St. Petersburg
Franckle, Cornelius S. St. Petersburg
Frederick, A. R. St. Petersburg
Gable, Linwood M. St. Petersburg
Gable, Nonie Wilson St. Petersburg
Gable, Nonie Worth St. Petersburg
Green, Thadeus H. St. Petersburg
Griffin, Thomas R. St. Petersburg
Groves, W. H. Clearwater
Guinand, P. H. Clearwater
Hagood, John Clearwater
Harden, W. W. St. Petersburg
Hardenbergh, John A. St. Petersburg
Hebard, C. E. St. Petersburg
Heibner, Eugene A. St. Petersburg
Herring, John A. St. Petersburg
Hood, J. Sudler Clearwater
Horne, Lester W. St. Petersburg
Jennings, Frank S. St. Petersburg
Kauffman, Frank E. Clearwater
Knowlton, R. H. St. Petersburg
Kumm, Frederick F. St. Petersburg
Lambdin, L. St. Petersburg
Langley, Francis H. St. Petersburg
LeBreton, Prescott St. Petersburg
Leith, Richard B. St. Petersburg
Lochner, G. M. St. Petersburg
Lustig, Emil St. Petersburg
McConnell, Whitman C. St. Petersburg
MacCordy, Earl C. St. Petersburg
Marr, Norval M. St. Petersburg
Mease, John A., Jr. Dunedin
Miller, George E. St. Petersburg
Mills, A. L. St. Petersburg
Morgan, Thomas E. St. Petersburg
Mount, Louis B. St. Petersburg
Murphy, Ralph D. St. Petersburg
Nelson, Orville N. Bay Pines
Nettles, Robbins Clearwater
Nickle, Millen A. Clearwater
O'Brien, Raymond K. St. Petersburg
Owen, W. S. St. Petersburg
Palmer, Harrison G. St. Petersburg
Post, William G., Jr. St. Petersburg
Prather, B. T. St. Petersburg
Quicksall, J. Braden St. Petersburg
Rogers, H. M. St. Petersburg
Roope, A. P. St. Petersburg
Roush, Franklin W. St. Petersburg
Rudolph, Councill C. St. Petersburg
Simcox, Lawrence St. Petersburg
Solomon, H. D. St. Petersburg
Strickland, Jesse A. St. Petersburg
Stuart, M. H. St. Petersburg
Thurston, Leon St. Petersburg
Timberlake, Gideon St. Petersburg
Wade, Hugh W. St. Petersburg
White, Benjamin L. St. Petersburg
Whitford, Grace R. Ozona
Williams, Carl A. St. Petersburg
Wood, Alvin J. St. Petersburg
Wright, Claude B. St. Petersburg
Wylie, LeRoy A. St. Petersburg

Polk County Medical Society

Boulware, James Lakeland
Carefoot, G. H. Ft. Meade
Clark, Samuel A. Lakeland
Cline, R. L. Lakeland
Hughes, Robert L. Bartow
Lester, John G. Lakeland
Lindsey, Sherrod A. Ft. Meade
Martin, Emmett E. Haines City
Murphy, C. H. Bartow
Nicholson, L. B. Lakeland
Overstreet, George C. Lakeland

Pease, Charles W. Tampa
Roberts, Tenney H. Lakeland
Tillis, W. L. Lakeland
Williams, E. L. Ft. Meade
Wilson, John F., Jr. Lakeland

Putnam County Medical Society

Brantley, Z. Grandin
Williams, W. J. Seville

St. Johns County Medical Society

Britt, Reddin St. Augustine
Hilborn, Robert R. Bunnell
Lockwood, Vernon A. St. Augustine
White, Herbert E. St. Augustine

St. Lucie-Okeechobee-Indian River-Martin County Medical Society

Clark, H. D. Ft. Pierce
Hardee, E. B. Vero Beach
Sample, A. M. Ft. Pierce
Whiddon, Lester L. Ft. Pierce

Sarasota County Medical Society

Burgner, Blanche A. Sarasota
Harris, J. E. Sarasota
Kennedy, David R. Sarasota
Patterson, John C. Sarasota
Shelby, Edmund P. Venice
Stem, Leon T. Sarasota
Taylor, T. W. Sarasota
Wilson, Cullen B. Sarasota

Seminole County Medical Society

Knox, A. W. Sanford
McDaniel, Thomas F. Sanford
Martin, John W. Oviedo
Smith, Henry D. Sanford

Sumter County Medical Society

Mitchell, W. E. Bushnell

Taylor County Medical Society

O'Quinn, C. A. Perry

Volusia County Medical Society

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this Journal, whether scientific papers or reports of County Secretaries, should be typewritten.

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Dr. Edward Jelks of Jacksonville is especially well qualified for the presidency of the Florida Medical Association. His election was a recognition of a man of retiring disposition, but a hard, faithful and conscientious worker in his chosen specialty. He has long been prominent in organized medicine in the South, having served as president of the Duval County Medical Society, president of the Florida East Coast Medical Association, and councilor for the Southern Medical Association from Florida. Also, he has filled capably the presidency of the Jacksonville Historical Society. Doctor Jelks is a Fellow of the American Medical Association, the American College of Surgeons, the Southern Society of Clinical Surgeons, the Southern Surgical Association, the Southeastern Surgical Congress, and a member of the Florida Medical Association and the Southern Medical Association.

Doctor Jelks was born in Hawkinsville, Georgia, in June, 1888. His boyhood was spent in Macon, Georgia, where, after receiving his preliminary education, he secured his A.B. degree from Mercer University in 1909. In 1913, Doctor Jelks graduated from the Johns Hopkins Medical School but remained there for two years after his graduation, during one of which he was Instructor in Laryngology of his Alma Mater. In 1915, he moved to Jacksonville, Florida, to practice his profession. He served in the Army for two years, eighteen months of which he spent in the A .E. F. in England and France. He was discharged with the rank of captain.

In 1917, he was married to Miss Isabelle Peyton Welch, whose father, Dr. George E. Welch, practiced medicine in Putnam County for about fifty years.

Doctor Jelks is surgeon at the Riverside Hospital, having held that position since 1915; also, he has been on the Staff of the Duval County Hospital for the past fifteen years.

Among the many contributions which Doctor Jelks has made to medical literature are the following:

"Osteochondritis Deformans Juvenilis," J. Fla. M. A., 3: 257-259 (Mar.) 1917.

"The Advantages of the Proper Handling of Acute Appendicitis," J. Fla. M. A., 4: 37 (Aug.) 1917.

"Observations on Some of the Common Surgical Conditoins of the Knee," J. Fla. M. A., 7: 20 (Aug.) 1920.

"Report of 346 Cases of Appendicitis from the Riverside Hospital, J. Fla. M. A., 10: 162-164 (Dec.) 1923.

"Observations on a Visit to Some European Medical Centers," J. Fla. M. A., 12: 106-108 (Oct.) 1925.

"Some Observations on Diseases of the Thyroid Gland," J. Fla. M. A., 12: 161-164 (Dec.) 1925.

"Post-Operative Massive Collapse of the Lung: Report of a Case," J. Fla. M. A., 13: 14-17 (July) 1926.

"Congenital Hypertrophic Pyloric Stenosis," J. Fla. M. A., 13: 268-270 (May) 1927.

"Fractures of the Spine," J. Fla. M. A., 15: 145-146 (Sept.) 1928.

"Ephraim McDowell," J. Fla. M. A., 16: 301-303 (Jan.) 1930.

"Doctor John Gorrie, Inventor of the First Artificial Ice Machine," Annals of Medical History, 1931, New Series, 3: 387-390.

"Dr. Henry Perrine," J. Fla. M. A., 20: 459-462 (April) 1934.

"Some Points in Early Diagnosis of Gastro-Intestinal Cancer," J. So. M. A., 28: 446-450 (May) 1935.

"Health Insurance in England," J. Fla. M. A., 23: 26-28 (July) 1936.

THE ST. PETERSBURG MEETING

Congratulations to the Pinellas County Medical Society, our host at the 64th annual meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6, and 7! The total number registered at this meeting was 658 which surpassed all previous records. There were 361 members registered which is a splendid showing when the time of the meeting is considered. In order to secure adequate hotel facilities, it was necessary to have this annual meeting the early part of April which prohibited many of the members from attending the meeting. At the Jacksonville meeting, held in 1934, there were 401 members registered. This record of members registered at an annual convention has not yet been surpassed; in the other registered groups, the St. Petersburg meeting seems to hold the record, with 77 visitors, 54 exhibitors, and 166 members of the Woman's Auxiliary, making a total of 658.

The St. Petersburg meeting was a success from start to finish. The county society officers and committeemen, as well as the local Woman's Auxiliary, made elaborate preparations for this convention and continued their enthusiastic efforts in entertaining and looking after the comfort and pleasure of those in attendance, throughout the entire meeting.

The Association dinner on Tuesday evening was a very elaborate affair and attended by 449 members and guests. The loud speaker was in good working order at this part of the program, so that everyone in the spacious dining room could hear the speakers, the musical selections and other entertainment. Following the Association dinner, those present retired to the ballroom and enjoyed an excellent floor show and good dance music. The Smoker on Monday night in the Yacht Club was also a most enjoyable affair. The Woman's Auxiliary looked after the entertainment of the ladies, to their entire satisfaction. The golf tournament was handled in a very efficient manner. A large number of doctors entered the tournament and there were some unusually desirable and costly prizes awarded on Wednesday noon. A description of the prizes and donors will be found in the proceedings of the meeting in this Journal.

The personnel of the Vinoy Park Hotel was most courteous in looking after the needs and comfort of everyone. This headquarters hotel was very large, beautiful, and unusually well planned for a meeting of this kind. This meeting in St. Petersburg will linger in our memories as one of the outstanding occasions of its kind.

Next year's meeting will be held in Miami. While the Dade County Medical Society is the strongest in the state in number, and even though Miami is also a city for winter visitors and well equipped for entertaining royally, it will require real effort on the part of the members of the Dade County Society to uphold the standard set by our good friends in St. Petersburg. Complete proceedings of the meeting, as well as the names of the new officers and committee appointments appear in this Journal.

THE DOCTOR OF TOMORROW

An article of the above title was recently delivered by Dwight Anderson before the Monroe County Medical Society at Rochester, New York.

The doctor is on trial before the court of public opinion with most of the evidence and the argument presented by groups intent on establishing a Government controlled health insurance organization throughout the entire country. The Medical Profession as a unit has not been seriously considered at present because the public looks upon its arguments as self-serving.

The doctor of tomorrow would find his work of diagnosis and treatment most difficult, if supervised by professional politicians and their henchmen. The politician of tomorrow cannot be expected to conduct the Government controlled public health insurance any more efficiently or economically than other government agencies are managed today.

There is some misunderstanding at present, both by the profession and among advocates of government insurance because different terms, as "State Medicine", "Socialized Medicine" and "Health Insurance," are used and different methods proposed to meet cost. Obviously the terms do not all mean the same thing. The latter term, "Health Insurance" is most likely the objective. Then if there is to be health insurance, possibly the greatest stumbling block, the thing with the most dynamite, is the method of raising and administering the finances or expense of the thing. This is where the professional politicians might control a large section of the profession and the public.

The most aggressive in waging the battle for compulsory health insurance is the American

Association for Social Security. They have been well financed and have used every facility to present a convincing case. We believe that it is admitted that they have overstated the facts in their records in the attempt to win the public to health insurance. Abraham Epstein has possibly exerted the greatest effort to have Government health insurance created into law. A bill carrying his name was introduced in Congress and some of the State legislatures a few years ago and was a part of the original Social Security Act but dropped in final passage.

The profession objects to the government administered compulsory health insurance for specific reasons: 1st, cost; 2nd, the patient-physician personal relation would be lost; 3rd, the physician would be the tool of professional politicians; 4th, the incentive to progress would be lost; 5th, the laymen are not medically trained and not able to supervise medical problems; 6th, the work would not be thorough with the doctor under pressure of work; 7th, taxation would have to be high to meet the high cost.

So far the Medical Profession has prevented hasty legislation through its efforts to convince the public and the law-makers that sufficient study must be made of the entire problem before passing a law. The profession feels that since other countries are experimenting in health insurance we should profit by their mistakes and attempt to have a better plan.

Undoubtedly the greatest contribution to be made by the profession will be to assist in forming a workable health insurance plan. Societies to finance the expense of sickness, the hospital expense and doctors' bills separately and jointly by small monthly payments are being tried in almost every section of the country today. Some nonprofit sharing plan built upon the experience of the present associations should be much safer and of the greatest benefit to the public and the profession of the future. The doctors of today must unite under a leadership of its best talent and secure a health insurance plan that will be economically sound and deal justly with patient and physician.

THE SIXTY-FIFTH ANNUAL MEETING
OF THE
FLORIDA MEDICAL ASSOCIATION
WILL BE HELD IN
MIAMI IN 1938

AMERICAN MEDICAL GOLFERS PLAY IN ATLANTIC CITY, MONDAY, JUNE 7, 1937.

The American Medical Golfing Association will hold its twenty-third annual tournament at beautiful Seaview Country Club, Atlantic City, New Jersey, on Monday, June 7, 1937.

Seventy Trophies and Prizes

Thirty-six holes of golf will be played in competition for the seventy trophies and prizes in the nine events. Trophies will be awarded for the Association Championship, thirty-six holes gross, the Will Walter Trophy; the Association Handicap Championship, thirty-six holes net, the Detroit Trophy; the Championship Flight, first gross, thirty-six holes, the St. Louis Trophy; the Championship Flight, first net, thirty-six holes, the President's Trophy; the Eighteen Hole Championship, the Golden State Trophy; the Eighteen Hole Handicap Championship, the Ben Thomas Trophy; the Maturity Event, limited to Fellows over 60 years of age, the Minneapolis Trophy; the Oldguard Championship, limited to competition of past presidents, the Wendell Phillips Trophy; and the Kickers' Handicap, the Wisconsin Trophy. Other events and prizes will be announced at the first tee.

1,300 A. M. G. A. Fellows in Every State of the Union

Dr. W. Albert Cook of Tulsa, Oklahoma, is President and Dr. E. S. Edgerton of Wichita, Kansas, and Dr. Clarence Capell of Kansas City, Missouri, are vice-presidents of the American Medical Golfing Association, which was organized in 1915 by Dr. Will Walter, Dr. Wendell Phillips and Dr. Gene Lewis, and now totals 1,300 members representing every state in the Union.

Application for Membership

All male Fellows of the American Medical Association are eligible and cordially invited to become members of the A. M. G. A. Write the Executive Secretary, Bill Burns, 2020 Olds Tower, Lansing, Michigan, for an application blank. Participants in the A. M. G. A. Tournament are required to furnish their home club handicap, signed by the club secretary. No handicap over 30 is allowed, except in the Kickers' (Blind Bogey). Only active members of the A. M. G. A. may compete for prizes. No trophy is awarded a Fellow who is absent from the annual dinner.

GRADUATE SHORT COURSE FOR DOCTORS OF MEDICINE IN FLORIDA JUNE 21-26, 1937

GENERAL INFORMATION

The fifth annual Graduate Short Course for Doctors of Medicine in Florida will be held at the Orange Court Hotel, Orlando, June 21-26, 1937. The first four sessions of the Short Course were held at the University of Florida in Gainesville, but this year, because of many requests throughout the state, a change has been made to Orlando.

PURPOSE

The purpose of the Short Course for Doctors of Medicine is to bring to Florida a group of nationally-known specialists in the field of medical science and to enable the physicians of the State to receive a short but intensive course of instruction in the newer methods of diagnosis and treatment.

FACULTY AND LECTURERS

Dr. Jesse Oglevee Arnold, Professor of Obstetrics, Temple University School of Medicine, Philadelphia, Pennsylvania.

Dr. Walter Lawrence Bierring, Former President of the American Medical Association, Commissioner, Iowa State Board of Health, Des Moines, Iowa.

Dr. Wilbur Emory Burnett, Assistant Professor of Surgery, Temple University School of Medicine, Philadelphia, Pennsylvania.

Dr. Francis Bayard Carter, Professor of Obsetrics and Gynecology, Duke University School of Medicine, Durham, North Carolina.

Dr. Ralph N. Greene, Medical Director, Eastern Air Lines, Inc., Coral Gables, Florida.

Dr. Alexander Jonas Schaffer, Department of Pediatrics, Johns Hopkins School of Medicine, Baltimore, Maryland.

SYMPOSIUM SPEAKERS

Tuberculosis

Dr. Pol N. Coryllos, Professor of Clinical Surgery, Cornell University Medical College, and Professor of Thoracic Surgery, New York Polyclinic Medical School and Hospital, New York City, New York.

Dr. R. D. Thompson, Superintendent of State Tuberculosis Sanatorium, Woodsmere, Florida.

Dr. T. M. Palmer, Jacksonville, Florida.

Neurosurgery

Dr. Claude C. Coleman, Professor of Neurological Surgery, Medical College of Virginia, Richmond, Virginia.

Dr. James Gilbert Lyerly, Neurosurgeon, Jacksonville, Florida.

PROGRAM

Monday, June 21

Morning

8:00- 9:00—Registration, Orange Court Hotel, Orlando.
9:00-10:00—Pediatrics, "Infant Feeding and the Avitaminoses" Dr. Schaffer
10:00-11:00—Neuropsychiatry, "The Examination of the Neurological Patient" ...Dr. Greene
11:00-11:30—Recess.
11:30-12:30—Medicine, "Cardiac Arrhythmias." Dr. Bierring

Afternoon

12:30- 2:00—Lunch.
2:00- 3:00—Neuropsychiatry, "Diseases of the Peripheral Nerves and of the Spinal Cord." Dr. Greene
3:00- 3:15—Recess.
3:15- 4:15—Medicine, "Vascular Hypertension." Dr. Bierring
4:15- 4:30—Recess.
4:30- 5:30—Pediatrics, "Urinary Infections and Nephritis" Dr. Schaffer

Tuesday, June 22

Morning

9:00-10:00—Pediatrics, "Infantile Tuberculosis." Dr. Schaffer
10:00-11:00—Neuropsychiatry, "Syphilis of the Central Nervous System" Dr. Greene
11:00-11:30—Recess.
11:30-12:30—Medicine, "Digitalis—When to Use It." Dr. Bierring

Afternoon

12:30- 1:30—Lunch.
1:30- 2:30—Neuropsychiatry, "Diseases of the Brain with Remarks on Traumatic Lesions of the Brain and Spinal Cord"..Dr. Greene
2:30- 2:40—Recess.
2:40- 3:40—Medicine, "The Anemias" ...Dr. Bierring
3:40- 4:40—Pediatrics, "Hazards of the Neonatal Period" Dr. Schaffer
5:00- 6:30—Inspection of new State Tuberculosis Sanatorium at Woodsmere; Demonstrations of Artificial Pneumothorax.
6:30- 7:30—Buffet Supper at Sanatorium.
7:30 —Symposium on Tuberculosis: "Trends of Surgical Treatment in Pulmonary Tuberculosis" Dr. Coryllos
"Transitory State in Childhood Tuberculosis" Dr. Palmer
"Value of Sanatorium Care for the Tuberculous Patient".....Dr. Thompson
(At Sanatorium)

Wednesday, June 23

Morning

9:00-10:00—Pediatrics, "Modern Serotherapy and Chemotherapy" Dr. Schaffer
10:00-11:00—Obstetrics, "Revising the Code of Prenatal Care" Dr. Arnold
11:00-11:30—Recess.
11:30-12:30—Medicine, "Diabetes and the New Insulin" Dr. Bierring

Afternoon

12:30- 2:00—Luncheon, "The Surgical Management of Pulmonary and Pleural Tuberculosis." Dr. Coryllos
2:00- 3:00—Neuropsychiatry, "Neurological Diseases of General Origin".....Dr. Greene
3:00- 3:15—Recess.
3:15- 4:15—Medicine, "The Art of Clinical Diagnosis" Dr. Bierring
4:15- 4:30—Recess.
4:30- 5:30—Obstetrics, "Prophylactic Problems of the Antenatal Life" Dr. Arnold

Thursday, June 24

Morning

9:00-10:00—Gynecology, "Infections of the Vagina, Cervix and Vulva" Dr. Carter
10:00-11:00—Surgery, "Diseases of the Breast." Dr. Burnett
11:00-11:30—Recess.
11:30-12:30—Obstetrics, "Labor Analgesics." Dr. Arnold

Afternoon

12:30- 1:30—Lunch.
1:30- 2:30—Surgery, "Diseases of the Gall Bladder and Diseases of the Appendix." Dr. Burnett

2:30- 2:40—Recess.
2:40- 3:40—Gynecology, "The Conservative Treatment of Pelvic Infections" ...Dr. Carter
3:40- 4:40—Neuropsychiatry, "The Problem of the Nervous Break-down" Dr. Greene
5:00 —Annual Barbecue, Orange County Medical Society.

Friday, June 25

Morning

9:00-10:00—Gynecology, "Endometriosis," Dr. Carter
10:00-11:00—Surgery, "Diseases of Colon, Rectum and Small Intestine" Dr. Burnett
11:00-11:30—Recess.
11:30-12:30—Obstetrics, "Operative Deliveries and Some of Their Dangers" (Forceps, Versions, Cesareans, etc.) Dr. Arnold

Afternoon

12:30- 2:00—Lunch.
2:00- 3:00—Surgery, "Gastric and Duodenal Ulcer. Gastric Malignancy" Dr. Burnett
3:00- 3:15—Recess.
3:15- 4:15—Gynecology, "Special Diagnostic Measures in Gynecology" Dr. Carter
4:15- 4:30—Recess.
4:30- 5:30—Obstetrics, "The Occiput Posterior, and Other Common Causes of Dystocia." Dr. Arnold
7:30 —Symposium on Neurosurgery: "Management of Acute Cranio-cerebral Injuries" (45 minutes) Dr. Coleman
"Surgical Procedures for the Relief of Pain" (20 minutes) Dr. Lyerly
"Treatment of Spinal Cord Lesions: (a) Injuries, (b) Tumors" (45 minutes). Dr. Coleman

Saturday, June 26

Morning

9:00-10:00—Gynecology, "Backache in the Female." Dr. Carter
10:00-11:00—Surgery, "Infections and Surgical Emergencies" Dr. Burnett
11:00-12:00—Obstetrics, "Fluid-Balance and Dehydration in the Control of Eclampsia." Dr. Arnold

Afternoon

12:00- 1:00—Surgery, "Minor Surgical Office Procedures" Dr. Burnett

For complete program or additional information, write to Dr. T. Z. Cason, Chairman, Committee on Medical Post-Graduate Course, Jacksonville, Florida.

BIRTH CONTROL WINS

The National Committee on Federal Legislation for Birth Control has released information to the effect that a recent legal victory in the field of contraception was won through a decision of the U. S. Circuit Court of Appeals. This decision, which has been hailed as a Bill of Rights for the medical profession, was handed down in a test case on the importation of some Japanese pessaries sent to a physician for research purposes. A verbatim copy of the decision may be secured in pamphlet form from the Committee by addressing it at 1343 H Street, N. W., Washington, D. C.

The communication of the Committee further states that "the American medical profession has at long last been liberated from the stigma and restrictions imposed by the 'Comstock' law, enacted over sixty years ago. Making clear that the three sections of the statute must be construed as a unit, the judges said: 'We are satisfied that this statute . . . was *not* to prevent the importation, sale or carriage by mail of things which might intelligently be employed by *conscientious* and *competent* physicians for the purpose of saving life or promoting the well being of their patients.' "

The Committee's communication further states that "since the Government rests its case and will not carry it to the Supreme Court, this decision becomes, in effect, the law of the land."

STATE NEWS ITEMS

Dr. Julius C. Davis, Chairman of the Committee on Legislation and Public Policy of the Florida Medical Association, requested permission of the Kansas Medical Society to quote from a brochure published by them, in connection with the need for a basic science law. Doctor Davis received from Dr. C. G. Munns, Executive Secretary of the Kansas Medical Society, an immediate telegram of consent, advising that "Kansas is flattered to extend full reprint privileges," and further stating that no credit was desired by them as they believed better results could be obtained in Florida by not mentioning the publication.

This is to inform the members of our Association of the splendid cooperation given by the Kansas Medical Society. All members of our Association by this time have received the booklet entitled "Why Does Florida Need a Basic Science Law and Improved Medical Practice Act?"

* * *

Dr. W. E. Wentzel of Oshkosh, Wisconsin, has become associated with Dr. Hubbard Gates in Bradenton. Doctor Wentzel is a graduate of Northwestern University and served his internship at Milwaukee County Hospital, Milwaukee.

* * *

The third annual meeting of the American Neisserian Medical Society will be held on June 8, 1937, in the Senator, Atlantic City. The program will consist of papers and discussions on the various phases of the management and control of gonorrhea. All who are interested are cordially invited to be present.

The Orlando Barbecue and Picnic, fostered by the Orange County Medical Society, is a red letter day in the life of the Florida Medical Association. This event will take place at the Orlando Country Club, Thursday evening at 6 o'clock, June 24, 1937. All members of the Florida Medical Association are invited to attend. More about this picnic and barbecue will follow in next month's Journal.

* * *

Dr. W. W. Kirk and Dr. A. B. Quasser of Jacksonville, were among those in attendance at the New Orleans Graduate Medical Assembly, March 8-11.

* * *

Dr. Shaler Richardson of Jacksonville, Secretary of the Florida Medical Association, spent a week in New York recently, where he attended the meeting of the New York Ophthalmological Society.

* * *

Dr. C. M. Sandusky of Jacksonville, announces the removal of his offices to the Professional Building.

* * *

Dr. L. M. Anderson, Lake City, was appointed the first honorary member from Florida of the Southern Medical Association. Provision for honorary membership was worked out at the meeting held in Baltimore. The Secretary of the Southern Medical Association advised Dr. Anderson that it was a great privilege to number him among that small group who are entitled to honorary membership.

* * *

Dr. James B. Parramore, formerly of Jacksonville, has been appointed Director of the Monroe County Health Unit and Community Clinic at Key West. Doctor Parramore recently took a post-graduate course in public health at the Public Health School of the University of North Carolina.

* * *

Dr. E. T. Sellers of Jacksonville spoke before the Florida State Conference on Social Welfare held at Ocala, March 15-17. His subject was "The Venereal Disease Problem in the State of Florida."

* * *

Dr. and Mrs. John S. Helms, Jr., of Tampa spent the first three weeks of April at the Mayo Clinic where Doctor Helms attended surgical clinics.

Dr. W. E. Wentzel of Bradenton was recently elected a member of the Manatee County Medical Society. He will be associated with Dr. Hubbard Gates.

* * *

The many friends of Dr. J. E. Harris of Sarasota will regret to learn of the death of his father, Dr. J. F. Harris. Doctor Harris, who was 80 years of age at the time of his death, had lived with his son since 1926 and had many friends throughout the state.

* * *

Dr. James L. Borland of Jacksonville has located in the Medical Arts Building where he will limit his practice to gastro-enterology.

* * *

Dr. and Mrs. G. H. McSwain and Dr. and Mrs. C. H. Kirkpatrick of Arcadia, attended the New Orleans Graduate Medical Assembly, March 8-11.

* * *

Dr. C. R. Burbacher of Miami, announces the removal of his offices to 227 Avenue Aragon, Coral Gables.

* * *

Dr. and Mrs. Duncan T. McEwan of Orlando, announce the birth of a son, Bruce, on March 19, 1937.

* * *

On March 11, Dr. Victor Hughes spoke on appendicitis before the Parent-Teacher Association at the Grand Park School, Jacksonville, and Dr. Frederick Waas of Jacksonville spoke on appendicitis at the Springfield School No. 8.

* * *

Dr. and Mrs. S. B. Forbes of Tampa will leave for Vienna about June 25, where Doctor Forbes will do eye, ear, nose, and throat post-graduate work for the remainder of the summer. They will return some time in October.

FRANCISCO MARIA FERNANDEZ

Dr. Francisco Maria Fernandez of Miami died February 14, 1937, of coronary thrombosis and diabetes mellitus. Doctor Fernandez was 59 years of age.

Doctor Fernandez graduated from the Columbia University College of Physicians and Surgeons, New York, in 1908. He was a member of the American Academy of Ophthalmology and Otolaryngology; a fellow of the American College of Surgeons; past president of the Pan-American Medical Association; formerly Cuban

secretary of state and Cuban secretary of sanitation; at one time assistant professor of ophthalmology at the University of Havana Faculty of Medicine; former chief of clinic, eye department, Mercedes Hospital, Havana. He had been decorated by several governments.

Doctor Fernandez's life was one of the most colorful and interesting. Since he started practicing as ophthalmologist under the late, famous Dr. Santos Fernandez at Havana, he obtained credit for his outstanding preparation and dedication, being decorated by the Italian Crown for research work in cancer of the eye. For many years he was chief of the eye clinic of the Cavadonga Hospital in Havana where he collected about 200,000 clinical histories. He organized several of the most important National and International Medical Conventions held in Havana, as general secretary for many years and lately as President of the Cuban Federation of Physicians. As Secretary of Sanitation, his work was excellent and he was recognized and decorated by almost every civilized country in the world for his contributions to international sanitation. When the downfall of the Machado government in 1933 came, Doctor Fernandez was a member of the Senate and had to exile himself to Miami where he held a successful practice until the time of his death.

He leaves his widow, a member of one of the oldest Cuban families, and a son, Frank, now finishing his law studies at Miami University.

JAMES MULLINS GRANTHAM

When Almighty God would give to the world a great physician he must first find a noble man. For even the Creator Himself cannot take a man of small and selfish spirit and transform him into a Christ-like healer of the wounds of the world.

In the person of Dr. J. M. Gantham, God had found such a man. After an intimate friendship covering a span of 39 years, I am obliged to say that he would have stood at the forefront in any vocation in life. He was an alert, young doctor, recently out of medical school, when first I came to know him at Port Tampa City in the spring of 1898. His highly professional manner, his utter devotion to his duty, the tenderness with which he ministered to God's stricken children, the skill with which he bound up the bleeding wounds of rich and poor alike—all these things marked him even in that early day as a man of medicine who would bring honor and distinction to his profession.

During all the years that intervened, our lives have run parallel. What a privilege it has been to know so intimately through these years one who was such a faithful servant of society. He was much more than a practitioner of medicine, honorable as that profession may be. For he combined with his practice a ministry of love and sympathy and understanding, together with wise counsel, wherever his pathway led. There flashes before my mind the face of a hopeless invalid. For more than four years she has been shut in, the victim of a malady for which medical science knows no cure. The average man among us would say, "Her case is hopeless. Her purse is depleted. Why, then, spend added hours seeking to minister to her?" But that was not the spirit of that noble man of whom I speak. Dr. Grantham went day after day for these many long years, bringing the gentle love of a true physician, and ministering to her mental and spiritual well-being, though he could not bring healing to her stricken body. She is only one of vast numbers who will wait with longing heart for the coming of this kindly Christian man.

There is no word with which more perfectly to describe the life of our beloved friend than those words which were spoken of a stalwart young Healer who came from the hills of Galilee to bless a stricken world. For it was said of Him, "He went about doing good."

Tampa and South Florida is fortunate to have had such a capable and Christ-like public servant pouring out his fruitful years among us. I do not hesitate to say that with all the fine men who have blessed and enriched this community, none has made a finer contribution than has this noble Christian physician. He honored the profession by keeping fully abreast with the times. He was as modern in these closing days of his useful life as when first I knew him nearly forty years ago, the clear-eyed, clean, alert young practitioner just out of his University.

Our community is greatly impoverished that he will not serve among us any more. It is for those of us who remain to take up his unfinished tasks, to be a bit nobler, a little stronger, just a little more gentle and Christ-like, and thus carry on in the work that was so dear to his own heart.

—Rev. A. Fred Turner.

DR. RANDOLPH'S SANITARIUM

4422 Herschell St. **Phone 2-2330**

JACKSONVILLE, FLORIDA



For Nervous and Mild Mental Patients, Including Liquor and Drug Addicts

Ideal suburban location for rest and privacy. Capacity limited to permit maximum study and care. All corner rooms, attractively furnished. Delicious food, well cooked and daintily served. Registered nurses, tactful and sympathetic.

Treatment consists of combination of medication, rest, recreation, exercise, diet, baths, massage and psychotherapy, carefully worked out for each case by resident neuro-psychiatrist. Routine of proper living established. Re-education for better adjustments to social and economic problems, with permanent cure of patient in view.

Established 1929 Registered A. M. A.

JAMES H. RANDOLPH, M. D.

Owner and Resident Neuro-Psychiatrist

DOWNTOWN OFFICE - 323 ST. JAMES BUILDING

COMPONENT COUNTY SOCIETIES

BROWARD COUNTY MEDICAL SOCIETY

THE BROWARD COUNTY MEDICAL SOCIETY HAS REPORTED 100% OF DUES PAID FOR 1937. THIS VERY ACTIVE SOCIETY HAS A MEMBERSHIP OF 28 AND IS HEADED BY DOCTORS G. S. McCLELLAN, PRESIDENT; B. F. BUTLER, VICE-PRESIDENT, AND O. C. BROWN, SECRETARY-TREASURER. CONGRATULATIONS!

COLUMBIA COUNTY MEDICAL SOCIETY

COLUMBIA COUNTY MEDICAL SOCIETY HAS JOINED THE GROWING GROUP OF 100% PAID SOCIETIES. HEADING THIS SOCIETY FOR THE CURRENT YEAR ARE DR. T. H. BATES, PRESIDENT; DR. W. S. NICHOLS, VICE-PRESIDENT; AND DR. M. W. SPEARMAN, SECRETARY-TREASURER.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held at the Santa Rosa Hotel in Sebring, February 9 at 9:00 p. m. The following were present: Members: Drs. Brewster, Chandler, Boorom, Highsmith, Eide, Bevis, Weems, McKnight, and Martin; visitors: Doctor Siron of Sebring and Doctor Wishard of Ohio.

Doctor Siron read a paper on "The Role of Milk in Acute Intestinal Intoxication" and Doctor Wishard spoke of his experiences in the Orient. It was decided to hold the meetings for the next six months in Wauchula, instead of rotating them between several cities as has been done in the past.

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular meeting on the evening of March 30 at the State Board of Health Building in Jacksonville. The scientific program consisted of a symposium on abdominal cancer as follows:

"Early Diagnosis of Abdominal Malignancy," Edward Jelks.

"Malignancy of Upper Intestinal Tract," J. Knox Simpson.

"Malignancy of Lower Intestinal Tract," Harold VanSchaick.

"Malignancy of Female Pelvic Organs." (General Discussion.)

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. J. T. Bradshaw of Dade City entertained the Pasco-Hernando-Citrus County Medical Society Thursday evening, March 11. Dinner was served at the Edwinola Hotel, after which a scientific meeting was held. Drs. William Haywood Walters, Jr., of Lacoochee and Claude L. Carter of Inverness were elected to membership in the Society.

Action was taken by the Society, endorsing the proposed Basic Science Law and Improved Medical Practice Act for the State of Florida. A motion was made and carried that the doctors from each county in the Society contact the members of the Florida Legislature with reference to the Bills sponsored by the Association.

Clinical cases were reported and discussed and interesting talks made by the Society's new members. Dr. R. D. Sistrunk invited the Society to hold its next meeting as his guest in Dade City on Thursday evening, April 8.

PINELLAS COUNTY MEDICAL SOCIETY

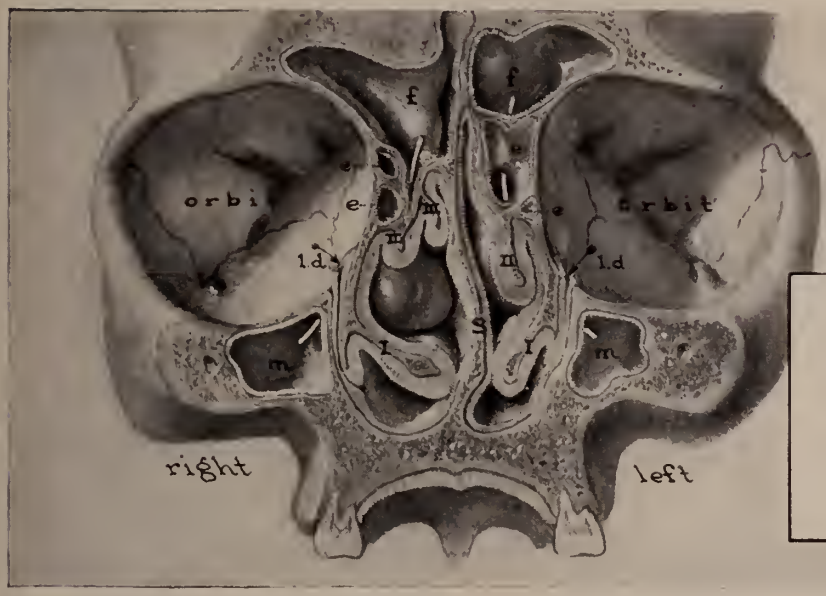
The regular meeting of the Pinellas County Medical Society was held Friday, March 19, at the El Ricardos. This was in the form of a pre-convention meeting, including the wives of the members.

A final checkup was made through the chairmen of the various committees, in connection with entertaining the 64th annual convention of the Florida Medical Association. This review of the plans of the committees revealed that the work of the members of the society had left no stone unturned in making preparation for a fine convention. The officers of the society expressed their appreciation of the interest and loyalty of the members of the committees in looking after the magnitudinous duties required in completing the plans undertaken.

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY

THE ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1937. THIS SOCIETY HAS A MEMBERSHIP OF FOURTEEN ACTIVE AND ONE HONORARY MEMBER. DR. H. D. CLARK IS PRESIDENT, DR. R. C. BOOTHE, VICE-PRESIDENT, AND DR. G. C. HARDIE, SECRETARY-TREASURER OF THE SOCIETY.

IN SINUSITIS



With congestion of the nasal mucosa as here represented in section, it is obviously difficult to reach all affected areas with a liquid vasoconstrictor.

In sinusitis 'Benzedrine Inhaler' is especially useful. The structure of the rhinological tract is so complicated that, when congestion is present, the whole of the affected area cannot easily be reached by a liquid vasoconstrictor.

The vapor from 'Benzedrine Inhaler,' diffusing through the nasal cavity, reaches and relieves congestion. Thus it not only affords improved respiratory ventilation, but also helps to re-establish drainage of the accessory sinuses—an important factor in preventing acute attacks from becoming chronic.

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How am I, with only a few lines left, going to tell you what a good time we had in St. Petersburg? From the time when the Board members began to arrive on Monday morning, our hostesses had every minute of the time planned with delightful entertainment. And there were 148 doctors' wives there to enjoy the festivities, 71 Auxiliary members and 77 guests. Never have we had so many distinguished visitors, either. The president of the Auxiliary, A. M. A., Mrs. Robert Fitzgerald from Wisconsin, the president of the Southern Medical Auxiliary, Mrs. Frank Haggard from Texas, and the program chairman of the A. M. A. Auxiliary, Mrs. V. E. Holcombe from West Virginia, brought stimulating messages to us of national work and what other states are doing. And among our guests were Mrs. J. H. J. Upham and Mrs. Morris Fishbein. Dr. Fishbein spoke to us at our Auxiliary meeting particularly about the publicity which the A. M. A. is now giving the Auxiliary. Do you know that the A. M. A. Journal carries Auxiliary news every week and that there is always plenty of news to fill the space? Look for it when your husband brings the Journal home.

The most interesting part of our Auxiliary meeting was the report of the successful essay contest on tuberculosis. The state contest does not end until May first but most of the county contests are finished and all reports spoke of the unusual interest aroused by the contest.

All the past presidents were thrilled by the presentation of pins. These pins are half a caduceus with a ruby in the head and a guard bearing the initials FLA and the year of the president's service. Five presidents were present to receive these pins from the hands of the national president, Mrs. Fitzgerald—Mdmes. Wells, Robinson, Peek, McMurray, and Harden.

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The March meeting of the Woman's Auxiliary to the Duval County Medical Society was held on March 4 in the home of Mrs. F. W. Krueger. Hostesses for the afternoon with Mrs. Krueger were Mrs. J. H. Owens and Mrs. Gordon H. Ira. Mrs. John Mitchell, president, presided. Mrs. E. W. Veal and Mrs. C. E. Royce were elected as delegates to the St. Petersburg convention.

Dr. E. T. Sellers presented to the Auxiliary a plan to build an addition to the Duval County Hospital in order to make it adequate for the needs of the indigent sick and gave interesting data in regard to this project. At the close of Dr. Sellers' talk, the Auxiliary voted to go on record as approving the project in its entirety.

Dr. H. Marshall Taylor gave a most interesting lecture with the aid of motion pictures on the "Hygiene of Swimming."

* * *

Mrs. Wilburn Lassiter was elected president of the Alachua County Auxiliary at its annual meeting on March 12 held at the home of Mrs. Chester F. Ahmann. Other officers elected were: president-elect, Mrs. J. L. Summerlin; vice-president, Mrs. John E. Maines; secretary and treasurer, Mrs. C. F. Ahmann and Mrs. J. Maxey Dell, Jr., respectively.

* * *

Professor Buel Trowbridge of the faculty of Rollins College, spoke to the members of the Woman's Auxiliary to the Orange County Medical Society at their luncheon meeting on February 26. Mr. Trowbridge spoke on the relation of religion and medicine. Mrs. Spiers, Auxiliary president, reported that an additional box of clothing had been sent to the Children's Home Society in Jacksonville.

* * *

The Woman's Auxiliary to the Volusia County Medical Society met in Daytona Beach on March 9 with representatives from all parts of the county in attendance. A delightful dinner was held and then the meeting adjourned to the home of Mrs. H. L. Merryday.

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
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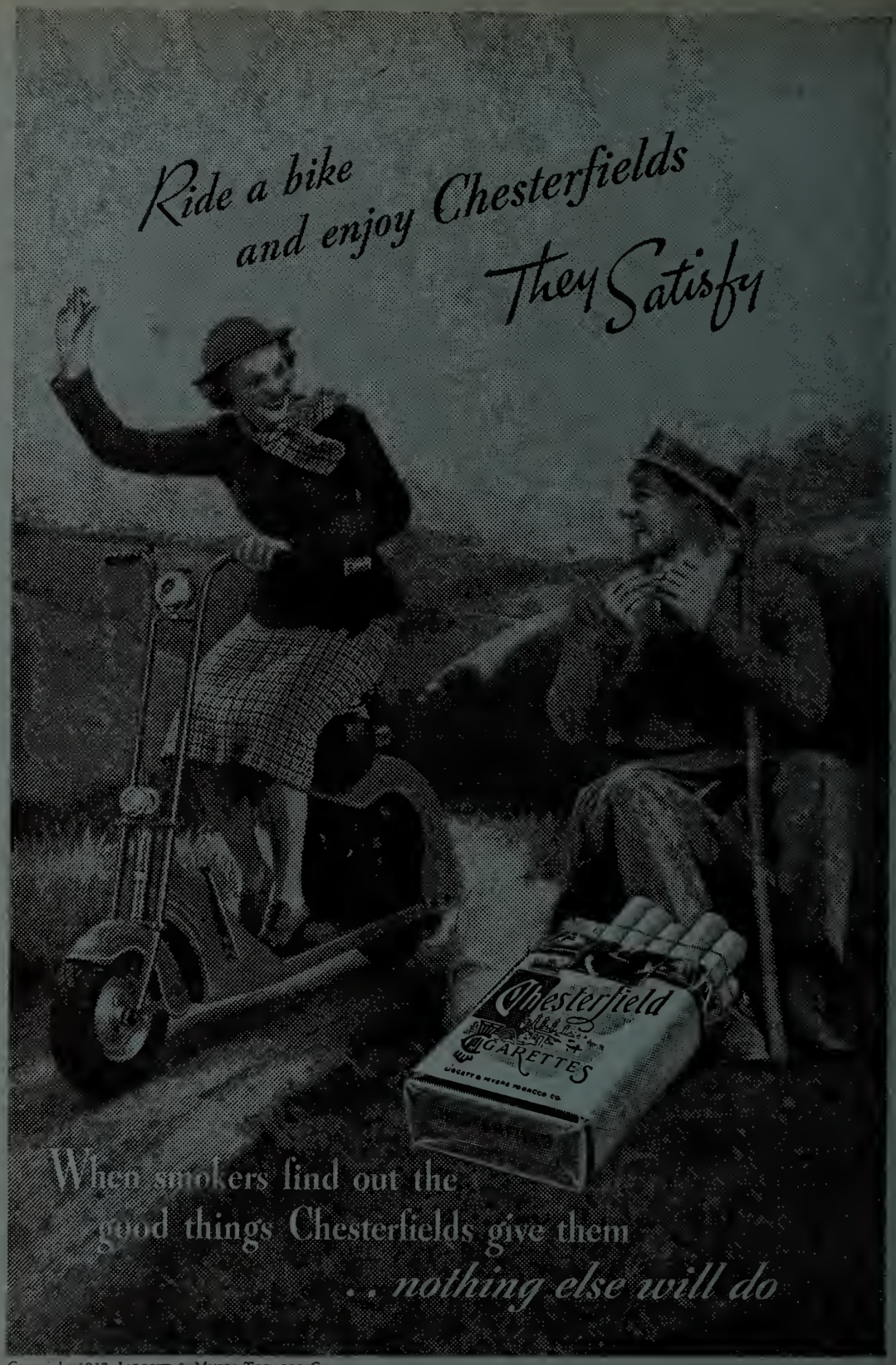
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COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	T. A. Snow, M.D., 103 E. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	19	70%
Bay	D. M. Adams, M.D., Panama City	Allen H. Miller, M.D., Millville			10	83%
Brevard	W. C. Page, M.D., Cocoa	Bob Schlernitzauer, M.D., Rockledge	3rd Tuesday	Varies	4	40%
Broward	George S. McClellan, M.D., Pompano	Oliver C. Brown, M.D., 915 Sweet Bldg., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	28	100%
Columbia	T. H. Bates, M.D., Blanche Hotel Annex Lake City	M. W. Spearman, M. D. Morrison Bldg. Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	11	100%
Dade	R. N. Burch, M.D., 1774 S.W. Eighth St. Miami	Walter C. Jones, Jr., M.D., 802 Huntington Bldg. Miami	1st Friday 8:30 P.M.	Elks Club	213	81%
DeSoto-Hardee-Highlands	Gordon H. McSwain M.D., Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	19	100%
Duval	Kenneth A. Morris, M.D., 237 W. Duval St. Jacksonville	George W. Croft, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	128	81%
Escambia	J. C. McSween, M.D., Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	33	83%
Hillsborough	George L. Cook, M.D., 443 W. Lafayette Tampa	James S. Grahle, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	95	97%
Jackson	C. H. Ryals, M.D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	12	80%
Lake	LeRoy H. Oetjen, M.D., Leeshurg	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 P.M.	Eustis	14	82%
Lee	H. Quillian Jones, M.D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M.D. 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	9	90%
Leon-Gadsden-Liberty-Wakulla-Jefferson	L. L. Dozier, M.D., Tallahassee	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	33	84%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			4	100%
Manatee	Lowrie W. Blake, M.D., Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	12	100%
Marion	Ralph E. Russell, M.D., Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	22	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	3	100%
Orange	F. H. Harms, M.D., 64 No. Court St. Orlando	Hewitt Johnston, M.D., Box 2002 Orlando	3rd Wednesday 8:30 P.M.	Varies	54	93%
Palm Beach	Bailey B. Sory, Jr., M.D., Brazilian Court Hotel Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	51	93%
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The JOURNAL of the Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XXIII
NO. 11

Jacksonville, Florida, May, 1937

Yearly Subscription, $3.00
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American Medical Association, Atlantic City, June 7-11, 1937.
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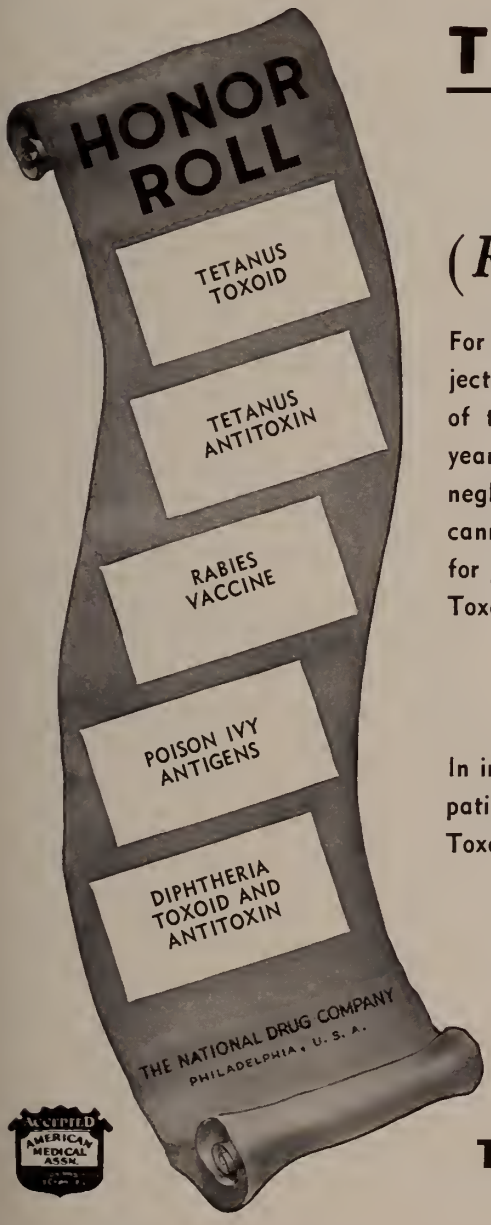
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Minimum human requirements for vitamin A are influenced by such variables as size of the individual and efficiency of absorption. The minimum daily requirement of infants has been estimated at 1500 International units, based upon the vitamin A content of milk. The need for the vitamin is not supplied by 1200 International units, while 2000 International units appear to be sufficient (2).

Although the minimum requirement of the adult has been estimated to be as low as 500 International units, the optimum level for both older children and adults is probably between 3000 and 5000 International units per day (3). The League of Nations Technical Commission recommends over 5000 International units of vitamin A for the pregnant and for the lactating woman (4).

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(1) a. 1935. J. Am. Med. Assn. 105, 1608
b. 1936. Ibid. 106, 996
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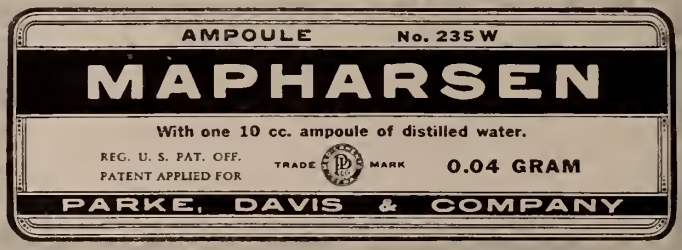
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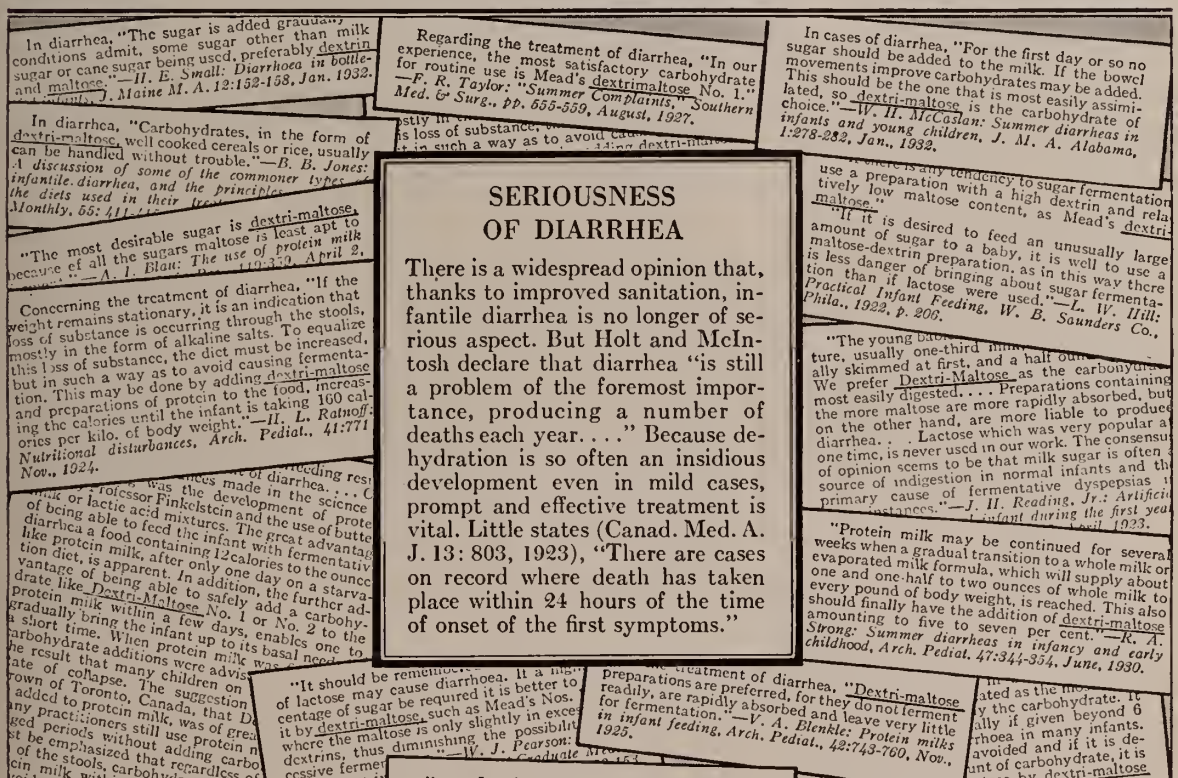
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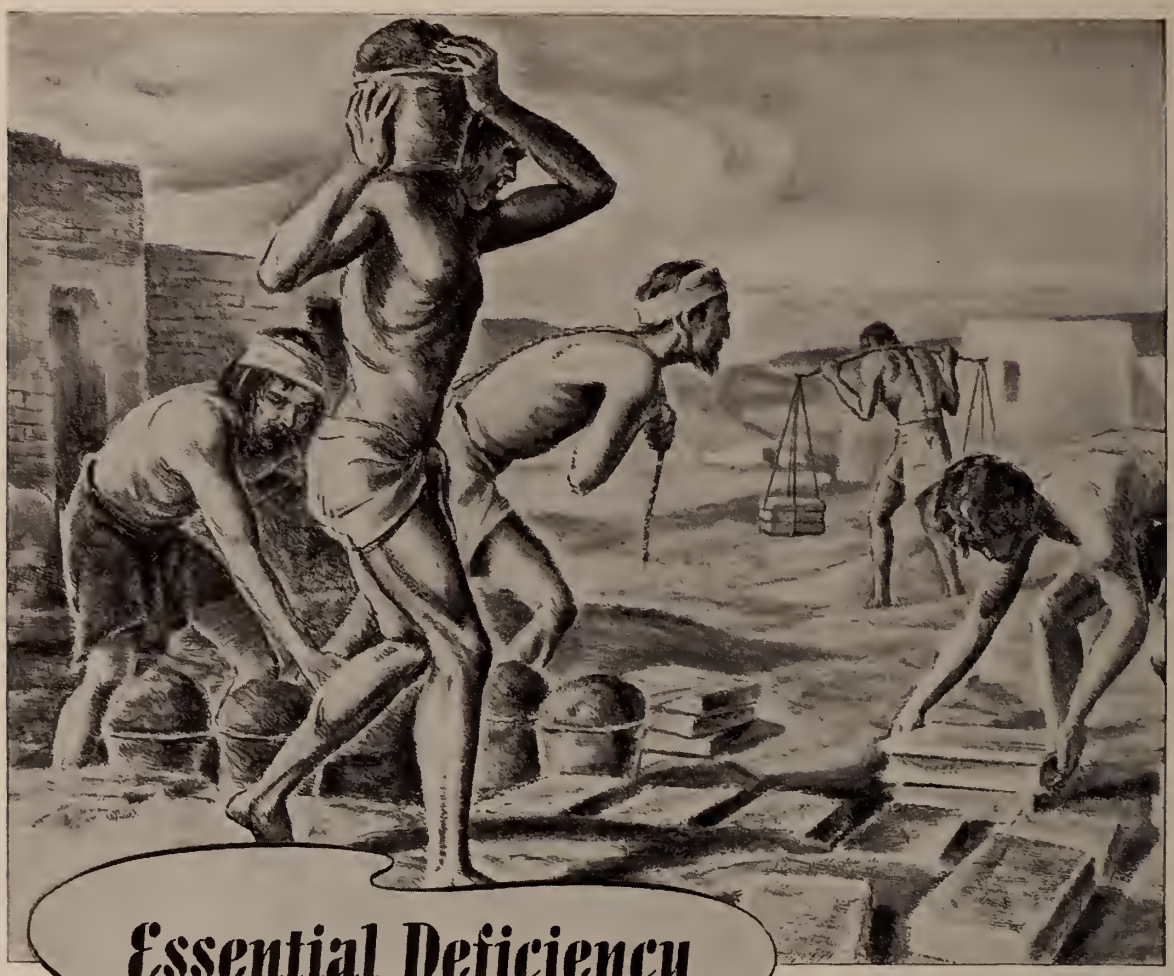
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PUBLISHED MONTHLY

Volume XXIII | Jacksonville, Florida, May, 1937 | Number 11

THE DIAGNOSIS AND TREATMENT OF TRIGEMINAL NEURALGIA*

H. Hamilton Cooke, M.D.,
Miami.

Major trigeminal neuralgia is a clinical entity characterized by sudden paroxysmal attacks of severe pain in the face. Accurate information about its frequency is not available. The average practitioner of medicine apparently observes more patients with this disease than is usually estimated. The numerous drugs, types of alcohol injections, and methods of surgical therapy proposed and used indicate the efforts made to bring relief to the unfortunate patients afflicted with this painful condition.

While severe pain in the face similar to tic douloureux was mentioned by Avicenna[2] (1000 years A. D.), it was not until 1756 that the disease was clearly differentiated and named by Nicholas Andre[1] of Paris. Fothergill[8] in 1773 published an inclusive, accurate, clinical description of what he called "a painful affection of the face." Charles Bell[3] in 1820 conclusively demonstrated by anatomical dissection and physiologic experiments that the fifth cranial nerve was the sensory nerve of the face. This discovery furnished a secure basis for the development of rational surgical treatment. Mears[19] in 1885 suggested the removal of the gasserian ganglion through the foramen ovale. Horsley[16] in 1891 resected the sensory divisions peripheral to the ganglion. Rose[21] in 1892 proposed an approach to the ganglion through the middle cranial fossa. Hartley[13] in 1892 independently described a similar technic. Krause[14] in 1893 described a transtemporal extradural approach to the peripheral divisions and improvements in the technic for the removal of the ganglion. Keen[17] and Spiller in 1898 suggested that trigeminal neuralgia could be permanently relieved by resection of the sensory root provided there was no regeneration of the nerve. The next important advance was begun by Frazier[10] in 1915 when he developed the subtotal resection of the sensory root conserving the ophthalmic fibers. Dandy[5] in 1925 reported the section of the posterior root near the pons by a suboccipital approach and in 1934 described[5] the results in 215 patients treated by this method.

Alcohol injection of the peripheral branches of the trigeminal nerve has been advocated by numerous workers. Levy[18] and Boudouin in 1905, Patrick [20] in 1907 and Hartel[12] in 1914 contributed important improvements to the technic of injecting the sensory divisions and the ganglion.

The specific etiology of trigeminal neuralgia is unknown. Numerous factors have been suggested and were enthusiastically supported for a time until found inadequate. Horsley[16] and Harris[11] considered that an ascending neuritis from dental caries was the cause, but it was soon proved that extraction of carious teeth did not arrest the pain. Frazier[9] proposed sclerosis of the ganglion as the etiologic factor. Dana[4] considered degenerative changes in the ganglion as the cause, but pathologic examinations have not shown any characteristic cellular changes. Ellis[7] believes that the neuralgia is caused by a toxic condition of the maxillary sinus filaments of the second division. Dandy[6] reports that in 60 per cent of 215 cases there were observed tumors, congenital anomalies, aneurysms, angiomas, adherence of the sensory nerve, or abnormal location of vessels which could be considered as the etiologic factor. The association of trigeminal neuralgia with migraine has been suggested as evidence of arterial vasospasm.

The characteristic symptom of trigeminal neuralgia is the severe paroxysmal attacks of pain. It is unique in not being expressed by other disturbances of the superficial or deep sensations. The attacks occur suddenly as a sharp, flashing, stabbing, lightning-like pain. The pain may radiate over one division or involve all three divisions. Patients frequently refer to a small area on the gums or on the cheeks which is more sen-

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the S.S. "Florida", April 27, 28 and 29, 1936.

sitive than the surrounding tissue. This so-called "trigger zone" is almost universally present in trigeminal neuralgia, and is pointed out by the patient as the area from which the attacks originate. Any form of irritation of the trigger zone such as eating, brushing the teeth, drinking hot or cold liquids, touching it with the tongue, talking or even swallowing may start the attack. The patient realizing the effect resulting from neglecting to protect the trigger zone will often refrain from eating or drinking. Each attack may last from one to two minutes and then suddenly disappear. The interval between each attack also varies, and occasionally it is so brief that the patient considers the pain continuous. At the onset of the disease the pain is frequently distinctly limited to a small area supplied by a few nerve filaments, but as the duration increases the pain involves a larger number of fibers and extends into the other divisions of the nerve. The attacks in the beginning may not recur for months or years, but with each recurrence the interval usually becomes shorter until finally the attacks become continuous. The attacks appear to be more severe in the Spring and Fall. During the interval between the attacks, the patient appears entirely normal except for a constant fear of further pain. There are no sensory changes present in trigeminal neuralgia. The pain is bilateral in one per cent of the cases. The diagnosis of trigeminal neuralgia is not difficult to make when the patient is observed during the acute attack. It is, however, important to emphasize that painful sensations from the face can be carried by either the fibers of the trigeminal nerve or the sympathetic fibers which surround the blood vessels. This is especially true in differentiating pain in the supraorbital area. Migraine, although unilateral, is readily distinguished from trigeminal neuralgia, since it is characteristically accompained by severe periodic headaches, which does not occur in trigeminal neuralgia. Painful sensations from dental caries or infected roots is usually readily localized by a careful oral examination. Painful sensations persisting after the extraction of infected teeth is usually caused by trauma to the terminal nerve filaments and usually disappears following local treatment. In sphenopalatine neuralgia the pain is constant and boring in character. It is usually localized over the hard palate, over the malar bone, or the lateral surface of the maxilla with a radiation of the pain down the lateral surface of the neck and towards the sphenoid. The pain differs from that observed in trigeminal neuralgia by not being constant. It is less severe and does not follow any of the anatomical divisions of the trigeminal nerve. Glossopharyngeal neuralgia is differentiated by the pain starting in the region of the tonsillar fossa and radiating along the course of the glossopharyngeal nerve toward the ear drum on the affected side. Postherpetic neuralgia is associated with a history of a rash. The pain is constant and there is a hyperesthesia of the skin. In pressure on the gasserian ganglion by tumors, bony abnormalities, aneurysms, or abscesses, there are definite cutaneous sensory changes over the side of the face and hyperesthesia of the cornea. The atypical facial neuralgias are characterized by a constant dull, throbbing pain which radiates along the carotid vessels and their larger branches.

The pain in trigeminal neuralgia is not relieved by the ordinary doses of the analgesic drugs or small quantities of opiates. Morphine should not be administered to these patients after the diagnosis is established, on account of the possibility of habit formation. No teeth should be extracted unless definite caries are present or other evidence of disease which would ordinarily be sufficient basis for extraction. Diathermy and roentgen therapy have been reported used in small groups of cases with uncertain degrees of improvement. Trichlorethylene should be used for the treatment of mild attacks. The patient should be instructed to place 20 to 30 drops on a handkerchief, lie down with two pillows under the head, and inhale the fumes until all odor has disappeared. This treatment should be repeated every two or three hours during the attack and twice a day for one week after the pain has disappeared. Alcohol injection into the peripheral nerve trunks has a definite place in the treatment of trigeminal neuralgia. The injection of 80 per cent alcohol directly into the nerve gives immediate relief for several months to two or three years. It also serves as a diagnostic measure and acquaints the patient with the sensation of permanent numbness which necessarily follows a partial or complete root section. The technic of injecting alcohol directly into the different divisions of the trigeminal nerve has been recently described in detail by Horrax.[15] In my experience the superficial alcohol injection into the terminal nerve twigs through the supraorbital, infraorbital, and mental foramina gives only un-

certain, brief relief from light attacks. The deep injection into the mandibular and maxillary divisions at the foramen ovale or foramen rotundum is of distinct value. The division in which the pain began should always be injected first, since complete relief may result. The other divisions can be injected later if the pain persists. With aseptic precautions this procedure is not difficult after adequate experience. In my opinion deep alcohol injection of the ganglion should never be attempted. The seepage of small quantities of alcohol into the tissues about the extracranial portion of the mandibular or maxillary divisions may produce a considerable local inflammatory reaction. This is usually not serious and subsides after a few days treatment with hot salt packs or other simple procedures. Accidental escape of alcohol into the subdural space on injection of the gasserian ganglion or the ophthalmic division is a major complication which may result in meningitis or injury to the optic nerve.

Partial or complete resection of the sensory fibers of the trigeminal nerve is followed by complete permanent relief from pain. I have used Frazier's technic for subtotal resection of the sensory root. By this procedure the motor root and ophthalmic fibers are conserved. The operation is performed under a combination morphine, scopolamine and local anesthesia. The approach is transtemporal and entirely extradural. The middle meningeal artery is exposed at the foramen spinosum, ligated and divided. The mandibular division is found entering the foramen spinosum. The dissection is carried up along the mandibular division to expose the lateral surface of the gasserian ganglion until the cerebro-spinal fluid is seen pulsating under the arachnoid membrane. A curved incision about 1 cm. in length is made in the dura arachnoid, which exposes the ganglion and the sensory root. The sensory fibers are gently retracted from the motor root by blunt hooks, and that portion of the root sectioned corresponding to the divisions from which the pain originated. Caution must be used to avoid injuring the motor root or cutting the ophthalmic fibers. Injury to the motor root will result in paralysis of the temporal, masseter and pterygoid muscles. This will be permanent if the motor root is sectioned. Injury or section of the ophthalmic fibers will result in trophic keratitis and conjunctivitis. The incision in the dura arachnoid need not be sutured. All bleeding is arrested and the wound closed with interrupted sutures of black silk. The patient should be carefully observed after the operation to detect any hemorrhage or other complications. The eye on the side where the operation is done should be irrigated daily with a mild antiseptic solution. If the ophthalmic division has been sectioned, the eye should be protected with a shield for about one month, and examined at intervals by an ophthalmologist to detect any keratitis, conjunctivitis or herpes. I have no personal experience with the division of the posterior root using the subcerebellar approach originated and advocated by Dandy. This ingenious procedure has distinct advantages over the transtemporal approach, but it is considered technically more difficult. Bilateral trigeminal neuralgia which occurs in about one per cent of the cases, can be treated by subtotal resection of the trigeminal nerves since the motor root is conserved. No mortality should occur in the treatment of trigeminal neuralgia by alcohol injection. The transfrontal extradural subtotal resection of the trigeminal nerve should not be associated with a mortality of over two per cent.

Regardless of low mortality and excellent results, some patients refuse to accept surgical methods of treatment. The speaker has developed an instrument for the treatment of trigeminal neuralgia by electro-coagulation of the nerve. The instrument consists of a needle 2 mm. in diameter with a movable guide. The needle is introduced into the mandibular or maxillary divisions with a technic similar to that used in alcohol injection. When the patient complains of pain radiating in the distribution of the nerve, the trocar of the needle is withdrawn. A fine needle is introduced through the barrel and a few drops of one per cent novocaine is injected through the needle into the nerve. After a few minutes the area of anesthesia is tested by pricking the surrounding skin with a sharp pin. If there is doubt as to the position of the barrel in relation to the foramen ovale, this can be easily checked by a roentgen plate. After the exact location of the barrel is determined, an electro-coagulating unit is introduced 3 mm. beyond the tip of the shaft and the minimum coagulating current passed into the nerve. Experimental and clinical observations are being continued and will be reported later in detail. This method will permanently destroy the nerve extracranially, producing the effect of a surgical procedure by a simple technic.

SUMMARY

Trigeminal neuralgia is a disease characterized by recurrent severe paroxysms of pain in the anatomic distribution of the trigeminal nerve. It is bilateral in about one per cent of patients, and is most frequent between 50 to 70 years of age. The pain in trigeminal neuralgia can be differentiated from atypical facial neuralgia since it always follows the branches of the nerve, is not associated with headache, and is not accompanied by any sensory changes. It is advisable to begin the treatment by the injection of alcohol into the nerve which may arrest the pain for several years. Permanent relief can be obtained by subtotal section of the sensory roots by a transtemporal extradural approach. The mortality should in a large series not exceed two per cent. Facial paralysis and paralysis of the masseter muscles can be avoided by careful dissection. The motor root can be conserved and the ophthalmic fibers spared by a subtotal section of the sensory root. A new instrument for the electro-coagulation of the divisions of the nerve is described and the technic outlined.

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DISCUSSION

Dr. J. G. Lyerly, Jacksonville:

Dr. Cooke has brought out some of the most important features of tic douloureux. He has discussed the etiology, bringing out the theories, but the actual cause is unknown. Likewise, the pathology is unknown. On the other hand, however, we do know considerable about the diagnosis and treatment. There is no other disease of the body which has such a clear-cut symptomatology. There is no other pain like it. It is sudden in onset and sharp and lightning in character. It is set off by a light touch or some stimulus applied to the sensitive area or trigger zone in the distribution of the nerve affected. It is also paroxysmal in character. If we get a careful and accurate history of this symptomatology the diagnosis is almost certain to be correct. Of course there are conditions and atypical neuralgia which have to be differentiated, but Dr. Cooke has already gone into that.

Now as to treatment. We might divide the treatment into two classes: medical and surgical. As far as medicines are concerned, they are of little value in relieving the patient of the immediate attack, as well as of the future seizures. The best known drug is trichlorethylene, but it has been disappointing and unsatisfactory in most cases. It is used only in cases which are not suitable for alcohol injection or a major operation, due to some cardiovascular renal condition or some other serious disease. It may take several weeks to obtain relief from this drug and then it is only partial.

Now as to surgical treatment, there are two methods of procedure. Both methods are based on some form of destruction of the nerve, but in different locations. In the first method the nerve is destroyed peripheral to the ganglion, either by alcohol injection, electric coagulation or cutting

or avulsion of the nerve. In either case the relief is only temporary, as the nerve will regenerate in time. An alcohol injection is usually the method of choice for destroying the nerve peripheral to the ganglion. In order to give permanent relief of pain the second method is employed by cutting the posterior root of the ganglion, which requires an intracranial operation. This will secure a permanent cure for the patient. We are coming to advise patients to have this major operation more frequently. Why temporize with alcohol injections which give only temporary relief? The patient will come for operation sooner or later, and the sooner you operate the better will be the condition of the patient for operation. As soon as we are sure of the diagnosis we usually advise the patient to have the major operation and obtain a permanent cure. This does not carry a high mortality. It has a mortality of less than one-half of one per cent. So you see there is very little risk. Some patients and some doctors think they will have a facial paralysis after operation, but this is not true. Facial paralysis is governed by an entirely different nerve. They will have some numbness, but there will be no paralysis.

Dr. H. Hamilton Cooke, Miami (concluding):

I am very sorry that we did not have ample time to present this subject in detail, but I am happy that Dr. Lyerly so ably emphasized a few of the points in the surgical technic.

I would like to again stress that the use of diathermy and alcohol injections are only of temporary value. For permanent relief operative procedure is a necessity. There is no use to temporize with any of these procedures unless you have the complete cooperation of the patient.

I have been entirely dissatisfied with trichlorethylene. I do not remember a single case in which even partial relief from pain was obtained for any length of time.

TRICHINOSIS*

CASE REPORT—LOCALIZATION IN SEMICIRCULAR CANALS

THEODORE F. HAHN, M.D.
DeLand.

It is the purpose of this paper to report a case of trichinal infection in which there was an unusual localization of the *Trichinella spiralis*, and to review briefly a few of the important points in the pathology, symptomology and clinical course of trichinosis, for in spite of much study it still remains difficult of diagnosis.

Trichinosis is not so frequently reported in Florida, and does not seem to be as prevalent here as in other sections of the country, but as elsewhere it is frequently overlooked and diagnosed otherwise, either because it is not considered in the differential diagnosis, or its various forms are not understood. Statistical evidence, such as that of Queen,[16] would indicate an incidence ten times greater than diagnosed. Riley and Scheifley[17] found a 20 per cent incidence of trichinal lesions in cadavers at autopsy, a figure which seems unbelievable.

EPIDEMIOLOGY

That infected pork is the chief and almost sole source of trichinosis for man is well known. There is governmental control in many countries by meat inspection and public health education against the eating of raw pork but that the rat is the chief reservoir which keeps the *trichinella spiralis* in constant circulation is not so well known. Pig pens infested with rats are the chief origins of infected pork, for the pigs in killing rats feed on them and so ingest the parasites. When infected pork is eaten, it is usually infective only when it is eaten raw or partially cooked.

When infected pork is ingested, the parasites present are not sexually mature. In the upper part of the small intestine the larval forms develop into the sexually mature forms, usually in two or three days. After reaching maturity conjugation takes place, and the males, having accomplished their sole biological function, die; the females then penetrate the intestinal mucosa to lodge later in the lymphatics of the intestinal wall. After four or five days in this location the young are born, rapidly develop in a day or two into actively motile forms which soon migrate from the intestinal lymphatics to neighboring lymph glands from whence they go into the lymphatic duct, the subclavian vein and so into the general circulation.[3] The system thus becomes suddenly flooded with an enormous number of small, almost embryonic, parasites which penetrate into every organ and tissue on their way to their final resting place, the voluntary muscles. In this process many parasites die. The largest number of these parasites which reach the voluntary muscles lodge near the tendons

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association held in St. Petersburg, April 5, 6 and 7, 1937.

where encystment takes place. The parasites become surrounded by a fibrous tissue capsule which after six months may become calcified. Sooner or later the encysted parasites will die unless the meat is ingested by some other animal.

PATHOLOGY

Infection with trichinae seems comparable in many ways to that of a generalized bacteremia, the manifestations being both toxic and embolic. The researches of Bachman[2] have shown that a toxemia is present from the beginning, as can be shown early by a skin reaction, often positive on the second day of infection. This skin test has been refined by Augustine and Theiler,[1] McCoy, Miller and Friedlander,[12] Kilduffe,[10] Maternowska,[11] and Friedlander.[6] Whether the toxemia is due entirely to products of the trichinae or the destruction of muscle tissue is still debated, but would seem to be a true toxemia from the parasite as it is often present before there is localization in the muscles. One feature of the pathological changes produced is that which may result from localization of the parasites without encystment, resulting in tissue destruction and cellular infiltration which if occurring in a vital organ might produce serious results as that which occurs in the heart, the so-called trichinous myocarditis.

SYMPTOMOLOGY

Trichinosis in its ordinary forms may begin with gastrointestinal symptoms a few hours after ingestion of infected pork, or after an interval of five or six days with symptoms referable to bloodstream dissemination of parasites. In either case severe gastrointestinal symptoms may occur. Severe cramps, diarrhea, nausea, vomiting and griping which may persist until symptoms of bloodstream dissemination occur or they may persist until the disease runs its course. Which patients will develop which type seems to depend on factors such as dosage and previous gastrointestinal lesions. At the end of the first week symptoms of bloodstream dispersion take place over the gastrointestinal tract. These are partly toxic and partly mechanical due to embolic lesions. Fever is prominent, high in severe cases, and persists for two to eight weeks. Headache may be severe and simulate sinus pain. Generalized aching and severe muscular pains follow. Anorexia becomes marked and prostration is severe. A characteristic edema of the eyelids occurs in eighty-five per cent of cases, and subconjunctival hemorrhages are often seen. Petechiae have occasionally been described. Pulmonary lesions are common, present clinically in the form of bronchitis, rarely as a bronchopneumonia. Meningitic, poliomyelitic and encephalitic symptoms have been described. Weakness, anemia, and muscle soreness persist long after other symptoms disappear. Leukocytosis with eosinophilia is rarely absent, although in the earlier stages the eosinophilia may be slight or absent. One of the features of the clinical course is the suddenness with which symptoms may begin or cease.

Unusual forms of trichinosis fall chiefly into three groups: (1) those in which myocardial symptoms are predominant; (2) those in which lesions of the central nervous system are marked, and (3) those in which evidence of kidney damage is marked. This latter is rare.

In 1918 Simmonds[18] described myocarditis trichinous, which had been illustrated in 1906 by Frothingham.[7] Interest in this lesion has been revived by the papers of Weller and Shaw,[21] Dunlop and Weller,[5] Spink,[19] and Blumer.[3] Such damage to the heart as has been described has usually been permanent, leaving a weak, fibrous muscle instead of a thick, muscular ventricular wall. Cheney[4] called attention to the extreme hypotension often seen in the course of the infection.

The central nervous system lesions are varied. In many cases the parasite has been recovered from the spinal fluid or from the brain at autopsy.[9] Meyer[14] reported cases simulating meningitis. Spink and Augustine[20] reported cases simulating poliomyelitis as did Merritt and Rosenbaum.[13] Blumer[3] reported hemiplegia in an attack of trichinosis. All these also called attention to a trichinous encephalitis.[8] The kidney lesions have been rarely described.[15] Because of these varied types of trichinosis, and its variable onset, the diagnosis is often difficult and obscure.

DIAGNOSIS

The diagnosis and differential diagnosis will not be discussed in detail. The diagnosis is difficult, but if considered in the presence of a severe gastrointestinal febrile disease in which edema of the eyelids and rheumatic pains also occur, and in which a leukocytosis with eosinophilia occurs, a search for the parasite can be made and the Bachman skin test performed to lead to a correct diagnosis. In the differential diagnosis we must consider typhoid fever, sinu-

sitis, acute dermatomyositis, meningitis, poliomyelitis, encephalitis, amebic dysentery and septicemia.

TREATMENT

The treatment is only symptomatic as there is no specific remedy. Prevention is the prime requisite. During the depression there were many suits instituted against meat dealers because of trichinal infections. However, it is to be remembered that because of difficulties in technique, expense, and inconclusive results the microscopic examination of pork for discovery of trichinae has been abandoned by both the United States and German governments. In Germany it was found that one-third of the cases and fatalities occurred after ingestion of meat released to the trade after government inspection. It is therefore not to be supposed that individual dealers are to be expected to guarantee their meat or to set up inspection laboratories. The only sure preventative against trichinosis is the thorough cooking of pork and pork products, and the state through its public health agencies is educating the public to this.

CASE REPORT

Case O-f, age 44, female; occupation, storekeeper handling groceries, delicatessens and meats. The patient was first seen on September 16, 1936. One week previously and on one or two occasions in the following days she had eaten pork sausage fried and raw. Other members had also eaten similarly, and two children had been ill for three days with fever, diarrhea and muscle pains, taking home-remedies for self-diagnosed "intestinal flu". When first seen this patient had been ill for three days, beginning with nausea, vomiting, diarrhea and fever. On the fourth day (the first day seen) she had developed aching of the muscles of the shoulders, back and legs and complained bitterly of a severe frontal headache. There was evident a peculiar swelling of the eyelids and tenderness over the frontal sinuses. Temperature varied between 102-103, pulse was 110, respirations were twenty-four and there was a hard, nonproductive cough with no signs in the lungs or bronchi. There was diffuse abdominal tenderness and moderate abdominal distension. She gradually but slowly improved under symptomatic treatment for what was supposed to be influenza and sinusitis.

On the tenth day of her illness she again became quite nauseated, especially on attempting to sit up or change her position from one side to another. She became dizzy, felt as if objects were spinning about her, and fell to the right when attempting to sit up with eyes closed. There was a lateral nystagmus to the right, vertigo was almost continual and she complained of headache, "deeper in the head". There was no mental confusion, no paralysis, no muscle weakness and no rigidity of neck or Kernig's sign. Fever which had gradually declined again rose to 102-103, and a white count showed a leukocytosis of 13,600 with an eosinophilia of 23%. With the persistent aching muscles, the edema of the lids, and a subsequently elicited history of pork ingestion, and the other findings the diagnosis of trichinal infection was now considered. Biopsy was refused and Bachman's skin test was not performed due to lack of facilities. The vertigo continued severe for one week. Spinal tap was considered but not performed as no meningeal symptoms or signs developed. On the fourteenth day of the disease a leukocytosis of 15,000 with eosinophilia of 31% was evident. The fever declined gradually becoming normal after four weeks. Swelling of the eyelids and headache disappeared in the third week. Vertigo and nausea on assuming the upright position persisted one week after the cessation of fever, gradually diminishing in intensity. Six months later there persists a slight lateral nystagmus to the right, but there is no vertigo, ataxia, or dizziness. Encystment may have been hastened by large doses of calcium lactate as recommended by some of the writers mentioned. The diagnosis of trichinosis in this case was proven only on clinical evidence, but the history, the edema of the eyelids, the eosinophilia and the muscular pains are more than merely suggestive. This case is presented because of its unusual complication of vestibular symptoms and signs.

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DISCUSSION

Dr. H. L. Bryans, Pensacola:

I wish to compliment Dr. Hahn on his splendid presentation. We who are practicing in Florida with such a large rural area should keep in mind the symptoms of trichinosis. I feel that often cases develop which are not recognized and for that reason it is a timely subject. The Michigan Department of Health last year reported an unusual outbreak of trichinosis, in Roger City and vicinity. In several of the cases reported, the patients were ill for about a week before seeking medical attention. In all, there were four households involved which were designated as A, B, C and D. Cases first appeared at household A which was a few miles out from Roger City. Households B, C, D, were located within Roger City. On investigation, it was found that each household had eaten or obtained sausage at household A in the country, with the exception of one roomer in household C and he was the only one not affected.

A specimen of smoked sausage was obtained from household A and the examination by the Board of Health showed *Trichinella spiralis.*

There were 32 cases in the four households. The most unusual feature of this outbreak was the predominance of gastrointestinal symptoms including severe diarrhea and persistent high fever. About the second or third week these patients complained of stiffness and soreness in the muscles.

As Dr. Hahn stated the skin test differential blood count is of considerable value in the diagnosis.

Dr. Meredith Mallory, Orlando:

The case just presented is most interesting and Dr. Hahn should be congratulated upon bringing this subject to our attention. There are undoubtedly more cases of trichinosis in Florida that go undiagnosed than those that are diagnosed. As more people come here the incidence of the disease will probably increase.

As has been pointed out, the diagnosis is very difficult. In the first stage of the disease, or the gastroenteritis, one is more apt to think of food poisoning or other conditions causing acute upsets of the gastrointestinal tract, for at this stage the eosinophilia does not appear. This usually comes in the second week when there is presented the indefinite muscular pains which lead to the diagnosis of rheumatism, myositis, etc. The Bachman skin test will in time be a great aid and as it is gradually being perfected it is more reliable. Spink and Augustine of Boston report a series of sixty cases with fifty-nine positive results. However, there are certain individuals who are sensitive to foreign protein who may get a positive reaction. These cases should be checked by the precipitin test.

AMBULATORY TREATMENT OF FRACTURES OF THE HIP AND SPINE*

M. P. Travers, M.D.
Miami.

The causes assigned to nonunion in fractures of the neck of the femur have been many. Astley Cooper in 1820 conjectured that circulatory disturbance was the chief reason for nonunion. Age, presence of synovial fluid, interposition, and poor immobilization were other causes.

*Presented at Staff Meeting of St. Francis Hospital, Miami Beach, Dec. 7, 1936.

Schanz[1] found a high osteotomy in cases of nonunion of long standing resulting in fifty per cent bony union. His osteotomy was below the old fracture line and as a result of it, the neck of the femur was almost directly below the head, thus removing the shearing force. According to the theory of Roux, intermittent pressure stimulates bone production while tension inhibits it. Schanz's osteotomy thus changed the force exerted about the fragments from one of tension to one of intermittent pressure when the extremity was functioning. Inadequate immobilization in general causes tension and, thus, in the carpal scaphoid and the neck of the femur, fibrous union and nonunion often result. Since fifty per cent of the nonunion cases in Schanz's series healed with bony union, after pressure was substituted for tension as the force exerted on the fragments, we may believe that it was not the interference with the circulation, age, or the presence of synovial fluid that had been the prime factor in the nonunion of these cases.

Schmorl[2] found interposition in seventy-five per cent of a series of fractured necks of femur on which he operated. However, again since Schanz had fifty per cent bony union after his operations, a number of cases of interposition must have been among them. This leads us to suppose that there could be bony union despite interposition. Gaenslan[3] in 1936, experimenting with dogs, fractured the necks of several femurs, interposed the capsule between the fragments and sutured them there. He then spiked the hip with three knitting needles. Upon autopsy, some months later, there was bony union. This indicates that bony union can take place across interposed tissues. Clinically, it is also noted in many cases of nonunion of the lower extremities that use of a walking caliper usually hastens union. This may well be due to Roux's theory of bony union; when the fracture is subjected to pressure, interposed tissues would readily atrophy and give way before such pressure. Poor reductions done blindly, unchecked by lateral views, resulting in a poor immobilization, probably account for the greatest percentage of nonunion and fibrous unions. These cases are doomed from their onset to failure.

There is one class of cases in which circulatory disturbances may be said to definitely impede union; that is when the damage to the blood supply is sufficient to cause an aseptic necrosis of the head of the femur. This can be observed radiologically after about two months since the atrophy of disuse renders the rest of the femur less radio-opaque than the head which retains its lime salts by virtue of its lack of circulation.

INTERTROCHANTERIC FRACTURES

These fractures heal with almost any treatment. They do very well with simple traction whether Russell's or Buck's extension. The use of metallic fixation and plaster spicas are unnecessary. One gross error in particular can be committed; allowing the distal fragment to ride up due to insufficient traction. Failure to take several check-up radiographs and add five or ten pounds of weight when necessary results in a shortened leg.

FRACTURES OF THE BASE OF THE NECK

These fractures are extra snyovial posteriorly since the joint capsule covers only the medial two-thirds of the posterior surface of the neck. It was thought the reason this type of fracture practically always healed was due to this factor, and also, its better blood supply. It must also be taken into consideration, however, that these fractures are not displaced much and rarely have interposed capsules. The fragments have large surfaces, are easily apposed, and do not present the mechanical difficulties, in approximation, that a loose revolving head and small femoral neck do in medial and subcapital fractures. These fractures heal with the same treatment as that given for intertrochanteric fractures and, again, need not be subjected to the ordeal of a spica.

MEDIAL FRACTURES OF THE NECK IMPACTED IN A POSITION OF COXA VALGA

This is an unusual type of fracture which heals readily. Slight traction is necessary to counteract the muscular pull on the distal fragment. That this fracture does so well is not due to the impaction but to the fact that the position of the neck is almost beneath the head, thus eliminating the shearing force present in other positions. Occasionally an ambulatory pneumatic splint may be found useful in this type of fracture since it gives just the right amount of traction and immobilization necessary. With it the patient can go back to work a week after the injury, no other contraindication being present.

MEDIAL AND SUBCAPITAL FRACTURES OF THE FEMUR

The original treatment for this injury was sandbags and bed rest. In 1851 Buck's adhesive traction came into use; and in 1860 the Thomas

splint was invented. With this apparatus the treatment of these fractures never yielded more than about sixteen per cent of cures. Whitman began using his spica in 1904. From then on, the patients having bony union rose to a fifty per cent average. The factors of the synovial fluid, blood supply, and age were all still present; therefore the improvement in statistics was due solely to the better technique in reduction and holding this reduction with a cast. Whitman's method in recent years began falling into disrepute. Despite good care, there was a high incidence during the long immobilization of cerebral and pulmonary complications, and an average mortality of twenty per cent. Furthermore, muscular atrophy would often shrink the extremity and torso of the patient sufficiently to allow the trochanter to rise and produce coxa vara, thus substituting tension for the intended pressure. The long immobilization of the hip itself favored atrophy of disuse and poor general metabolism. The other joints of the injured extremity suffered from stiffness. Bohler in 1933 advocated a walking plaster spica. Recently local investigators[5] advocated the same method. It solves the problem of prolonged bed rest but it is a selected method since a great percentage of patients at this age cannot carry about such a contrivance, and, there are a number of objections similar to those of the Whitman spica in any method immobilizing so large an area for so long a time.

TREATMENT WITH BUCK'S EXTENSION AND THE THOMAS SPLINT

In a series recently published, the result was sixty per cent bony union by use of this method. In reviewing a series of ninety-seven fractures of the femur from 1930 to 1935 at Fordham Hospital, we checked the results of the first against the second traumatic services, the first using the simple Buck's extension and the second, the spica. However, in addition to the Buck's extension used, there was rotary traction made upon the affected femur to secure inversion, and weekly x-rays to check up on the traction. The patients on which the Buck's extension method was used did just as well as those with the Whitman spica, with the advantage of greatly lowered mortality. The better results obtained with a series using Buck's extension, we believe, was due to careful repeated clinical and x-ray examinations. This is a tedious method; yet, we feel that the poor results usually recorded with it may be due to economy and neglect. The Whitman spica method has the great practical advantage of enabling the patient to get along with only nursing care after the primary procedure. This is offset, however, by stiff joints and a high mortality rate. Furthermore, when coxa vara threatens within a spica, it is no easy matter to adjust the situation; while with adhesive extension it is a matter of a few more pounds of traction. Adhesive traction will hold an oblique shearing fracture of the shaft of the femur, which a plaster cast cannot hope to accomplish. Why, then, should its use be considered undesirable for a fractured neck of the femur, except that, unreduced and infrequently checked, it gets out of hand.

BONE GRAFTS

Krida, at Bellevue Hospital, uses tibial bone grafts for fractures of the femoral neck, placed after open reduction and drilling. He claims a high percentage of success. However, the objections to this method for general use are that the cases must be selected. The bone grafts aren't strong enough to immobilize the hip joints and, therefore, a short plaster spica must be used together with prolonged bed rest. These features and the mortality that must absolutely accompany such procedures in elderly people do not make the procedure suitable for general use.

THE SMITH-PETERSON NAIL

In 1931, Smith-Peterson[6] published a series of cases using an open reduction and his nail for immobilization. He claimed approximately seventy per cent bony union. This method appeared gratifying at first since it obviated the plaster cast and many of the difficulties associated with it. However, the mortality was as high as with the previous methods; also, at the end of some months' treatment, a number of these nails were seen to loosen, due to some atrophy around their smooth surfaces. These fractures were not only ununited, but the pin served to keep them separated. Whitman called attention to the fact that these large nails injured the cancellus bone of the neck and its blood supply. Murray added a feature to the procedure by transplanting a muscle flap and suturing it within the torn capsule to augment the blood supply in this area.

STEEL PINS

Moore[7] of North Carolina in 1935 began using stainless steel pins for fixation. Other methods

came into vogue using multiple wires and pins. The objections to these methods are the following: a number of them have been reported to have migrated; one punctured the common iliac causing death; another worked its way externally into a septic area causing an infectious pyoarthrosis, ending fatally. Involuntary reflex muscular action alone is sufficient to bend these pins. Therefore, they do not immobilize, but merely maintain a precarious approximation. These patients must still be confined to bed for a number of months, with the inconveniences and complications of prolonged bed rest in the aged. A number of these pins, besides migrating, have bent or broken, resulting in coxa vara, shortening, and nonunion.

STAINLESS STEEL CORKSCREWS

In 1936 a metal corkscrew was introduced for the immobilization of fractured necks of femurs. This screw has its external third threaded so that after its insertion a nut can be put on and tightened, thus compressing the fractured fragments. To avoid complicated apparatus this is better inserted under a fluoroscope after the fracture has been reduced. Its advantages are



A lateral view of the reduced and fixed fracture. Note the central location of the corkscrew in this plane. (Taken on fluoroscopic table.)



Angle of picture makes corkscrew appear nearer to the acetabulum than it is. It is inserted high so that if it bends, it will tend to compress the fracture line of this medial fracture of the neck.

as follows: it is much stronger than the steel pins; therefore, the hip does not need to be immobilized in plaster. Due to the threaded nut on one end and the corkscrew on the other, there is little chance of its loosening or migrating. The corkscrew can be introduced in a manner less traumatic than the Smith-Peterson nail. Its size is much smaller than the nail; therefore, destroys very little cancellus bone, yet has great strength. It has an advantage not present in any other type of apparatus, and that is compression. An accurate and visual reduction with good compression afforded in this manner produces a condition not unlike that present in impacted fractures which heal readily. Roux's theory demands pressure which this method provides. Other types of therapy may meet this requirement for bony union at the outset but soon, due to muscle or bone atrophy, or muscular pull, change the forces about the fracture to one of tension. The corkscrew may be inserted under local or avertin anesthesia in patients of any age, since it is a very atraumatic procedure. Braces and walking calipers are unnecessary. There have been only a small series of cases in which



E. G., school teacher. Returned to active duty in three weeks, with crutches and no cast. This print discloses some callus formation at the fifth month after injury. At present the patient walks unsupported by crutches, has no shortening or limp.

this apparatus was used. There was no infection or mortality. The patient can leave the hospital on crutches at the end of the second week and return to his occupation, if it is a white-collar position, at the end of the third week. This method avoids the adverse effects of long immobilization in bed and in plaster; prevents stiffness of adjacent joints; and restores the patient physically, mentally, and economically within a few weeks. The only requirement is the use of crutches, instead of the usual disability of months and years. It also coincides with the ideal in fracture treatment by interfering as little as possible with the normal function of the patient's body and the part affected. Two uses for which I believe this apparatus will be found of great service eventually, and for which there is no record of its being used, are reducing central fracture dislocations of the head of the femur through the acetobulum and slipping femoral epiphyses, which often give such poor end results with a spica.

As to infection, there is a risk in any open method; yet, with care and good technique, the risk is minimal in this operation and does not compare with the twenty per cent mortality from the plaster spica. Also, unlike other fractures, there is practically no alternate method to secure a good result.

There was recently reported three infections due to wires inserted in the tibia occuring in bone-lengthening operations. These incidents occurred to one operator in a short period of time and, in this instance, could be attributed perhaps to factors associated with this particular surgeon. Also, it may be said that inserting two pins in a traumatized bone and applying tension to them in an extensive bone-lengthening operation has more potentiality for infection than a simple corkscrew inserted through a one and one-half inch incision.

FRACTURES OF THE SPINE

Treatment in the fractures of the vertebral bodies, similarly to fractured hips, have been the subject of over-conservatism. Bohler of Vienna has advocated better immobilization and earlier exercise for these patients. Despite the absence of neurologic damage the average patient with a fractured spine has been kept bedridden for about three months. The compression fracture of a vertebral body once reduced cannot recompress itself without forward bending. If the other spinal processes are intact, a spine cannot collapse or telescope. Also, there is no great group of flexor muscles tending to bend the body forward and compress such a fracture. If an unpadded and well fitting plaster jacket supports the thorax it is difficult to see how a reduced fracture can become recompressed. Therefore, such patients, once reduction has been secured, can leave the hospital with a jacket as soon as their general condition is good enough. There is no reason why they cannot resume any white-collar jobs in a few weeks. Light exercise is beneficial; their healing rate should be faster, and the muscular and bony atrophy lessened because of the better metabolism produced by activity. Reductions of fractured spines should be checked by x-rays as carefully as reductions of the long bones. It is important to restore the normal curvature and avoid poor alignment of the weight bearing surfaces, with a resulting painful traumatic arthritis. These are the cases in which spinal fusion is sometimes necessary to relieve painful disability.

Fracture of the spine is a diagnosis made by

x-rays. Patients with mild back injury should have a radiograph taken if their symptoms do not subside shortly. There is no way of differentiating some strains from fractures. I have seen two cases in the past month which had been treated for backstrain for two years, which disclosed vertebral injuries with intractable traumatic arthritis. A second x-ray should be taken within a few weeks if localized vertebral pain persists even though the first picture was negative. A molecular fracture may give way sufficiently to produce x-ray signs by then. Finally, radiography is a science which is not mastered by the purchase of an x-ray machine. The experience required in reading a spine plate is equivalent to that required in doing a cholecystectomy and should be undertaken just as casually.

In the after-care of fractures of the vertebrae, if early exercise is secured there is no necessity for other treatment. Diathermy has its chief use in tissues that are weak and stiffened, from over-immobilization. No electrical apparatus will ever be made that will restore tissues to their normal physiology more quickly than their early natural function.

The specialty of traumatic surgery is one which concerns itself with injury. It is neither orthopedic nor general surgery. Orthopedics, strictly speaking, refers to the treatment of the developmental defects and diseases of bone as the results of infantile paralysis, bone tuberculosis, osteomyelitis, club feet, etc. It was not intended to encompass the treatment of trauma. Acute injuries and fractures are admitted to but few prominent orthopedic services throughout the country. In smaller cities the general surgical services often care for injuries to the axial skeleton (head, thorax and spine), while the orthopedic department usually cares for the extremities. However, when efficient handling of an active traumatic service is required, it usually must have special wards and surgeons interested in injury as it affects the whole organism, whether it be to the soft or hard tissues of the body, in the axial or centripetal portion of the skeleton. It should, of course, be added that many orthopedists, general surgeons and also general practitioners are outstanding in certain phases of traumatic surgery in which they have interest.

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EXPERIMENTAL STUDIES ON DYSMENORRHEA*

CASE REPORT

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Dysmenorrhea is one of the most troublesome of menstrual disturbances, causing many women to suffer from one to several days every month. In some cases the suffering is so severe that menstruation constitutes a monthly torture which, aside from immediate pain, leaves the patient worn and weak for many days afterward, and she lives in a constant dread of the next menstrual period. Even in the milder cases the constant recurrence of pain and physical and mental depression may gradually induce a serious condition of malnutrition and neurasthenia.

Dysmenorrhea is not a disease. It is a symptom. It is caused by a great variety of conditions and is a symptom of many pelvic diseases. However, no one organic lesion has been shown to be the essential or sufficient cause of menstrual pain, for every condition so considered at one time or another has been found to exist in some instances without any accompanying menstrual pain.

Dysmenorrhea is due to a combination of abnormal conditions, either local or general, or both. The work of the physician in each case should be to (1) determine the abnormal conditions present in that particular case, (2) to form an estimate of the relative importance of each in the causation of menstrual distress, and (3) to treat the patient accordingly.

Dysmenorrhea due to an obvious lesion which can be removed, of course, presents no particu-

*Read before the regular monthly meeting of the Orange County Medical Society, February 17, 1937.

lar problem. The troublesome type is that form which starts without obvious cause and persists without apparent reason, the so-called "essential dysmenorrhea."

It has been definitely established that the immediate cause of the severe cramping pains is increased contractility of the muscular wall of the uterus. If there is any doubt that muscular contraction can cause pain, just recall the suffering in intestinal cramps or the discomfort caused by a severe cramp in the leg muscles, the old-fashioned "Charley-horse."[1]

It is not the purpose of this paper to bring before you the time-worn remedies and various treatments of dysmenorrhea, but rather to present to you an entirely new, original treatment. This treatment is based on the theory that if the activity of the afferent and efferent nerve supply of the uterus and ovaries can be reduced, the increased contractility of the musculature of the uterus which causes the dysmenorrhea can be reduced and the amelioration of pain in direct proportion to the reduced contractility can be reasonably expected.

Physically, the organs responsible for dysmenorrhea are the female generative organs because these are the organs by which the act of menstruation occurs. Therefore, let us try to correlate facts and see just why there should be a basis for this treatment and why results of varying degrees can be expected.

Quoting verbatim from Cunningham's Textbook of Anatomy on the Structure of the Uterus: "The thick uterine wall is composed of three chief layers, which are termed respectively the serous, the muscular and the mucous coats. The tunica serosa, serous coat or perimetrium is derived from the peritoneum and covers the whole organ except that part of the cervix which projects into the vagina and the anterior surface of the supravaginal portion of the uterus. The tunica mucosa or mucous coat of the body of the uterus is smooth and soft and is covered by columnar ciliated epithelium. The tunica muscularis or muscular coat of the uterus is composed of unstriped or smooth muscle fibers and forms the chief part of the uterine wall. Inferiorly the muscular coat of the uterus becomes continuous with that of the vagina. The more superficial layer of the muscular coat sends prolongations into the recto-uterine folds, into the round and broad ligaments of the uterus and into the ovarian ligaments. Other fibers join in the walls of the fallopian tubes. The main branches of the blood vessels and nerves of the uterus lie among the muscle fibers. In the deeper layers of the muscular coat a considerable amount of connective tissue and some elastic fibers are to be found."[2]

Next let us consider the nerve supply of the uterus. As the body of the uterus is composed of smooth muscle tissue in its entirety, the nerve supply must come from the sympathetic and parasympathetic system.

Quoting from Amreich and Peham Operative Gynecology, Vol. 1, we find that the "pelvic organs are supplied by the so-called vegetative nervous system. Whereas the central nervous (cerebrospinal) system serves all the voluntary movements and conscious sensation necessary for one's animal existence, the vegetative nervous system maintains the activity of the involuntary organs thus regulating the vegetative life. The structures which the vegetative nervous system supplies are chiefly the glands, the organs consisting of smooth muscle and also the heart and the pharynx. All the organs supplied by the vegetative nervous system approach a definite function of their own, independent of the brain or spinal cord, even though they may be influenced by the central nervous system. The sympathetic chain on either side begins with the superior cervical ganglion and extends downward in segmental arrangements to the simple coccygeal ganglion. It receives preganglionic spinal fibers from the anterior horn of the spinal cord by way of the white rami communicantes. A portion of these fibers pass uninterrupted into the sympathetic chain to reach the distant ganglia of the sympathetic plexus, in which they synapse and from which their postganglionic fibers pass to the smooth musculature of the viscera. The parasympathetic fibers arise in the brain, the medulla oblongata and sacral cord. Without entering the sympathetic chain, these fibers pass along the cranial nerves and pelvic nerves to reach their ganglia which are located near the organs they supply.

"The sympathetic nervous system innervates all the structures which are supplied by the parasympathetic system and in addition a number which are innervated by the sympathetic alone. The sweat glands and the smooth musculature of the skin are the only structures which receive solely a sympathetic supply; all remain-

ing vegetative organs, the smooth muscle, certain involuntary striated (heart) muscles and the glands possess a dual innervation. The sympathetic and parasympathetic systems are antagonistic in action, the one supplying excitatory and the other inhibitory impulses to those structures having a double innervation. The parasympathetic fibers of the pelvis extend from the intermediolateral surface of the sacral cord. They pass by the posterior roots along the path of the pudendal anastamosis with the ganglion of Frankenhauser. From this ganglion the fibers pass to the uterus. The sympathetic fibers arise in the lateral horn of the lumbar cord and pass by the anterior roots and sympathetic cord into the inferior mesenteric ganglion. Then after a synapse, the postganglionic fibers pass without interruption along the path of the hypogastric plexus to reach the Frankenhauser ganglion and the uterus."[3]

So we can see that the uterus is composed of smooth involuntary muscle tissue and is supplied by both sympathetic and parasympathetic nerves arising in the lower lumbar and sacral cord. We know that smooth muscle is always in a constant state of tonus, the degree and extent of this tonus being governed by the antagonistic action of the parasympathetic and sympathetic systems.

As aforestated in this paper, essential dysmenorrhea has been shown to be due to increased contractility of the uterine muscle wall. Hence, anything that will reduce the activity of the nerves and reduce the conductivity of the nerves that supply the uterine wall will have to reduce the increased tonus and irritability of the uterine musculature and thereby reduce the dysmenorrhea.

In the February, 1936, issue of the American Journal of Obstetrics and Gynecology, Drs. J. P. Greenhill and Herbert E. Schmitz[4] of the Loyola University Medical School and the Cook County Hospital, reported eighty cases in which intraspinal injections of alcohol and sympathectomy for pain associated with inoperable carcinoma of the cervix, was used. In the summary at the end of their article they state: "A comparison of the series of patients treated by pelvic sympathectomy and the patients treated by alcohol injections demonstrates conclusively that better results are obtained by alcohol injections. In addition to the greater incidence of relief obtained by the means of alcohol injection this procedure is far simpler than sympathectomy. Among our first forty patients taken at random we have been able to obtain complete relief in eighty-five per cent of the cases, partial relief in five per cent of the cases and no beneficial results in ten per cent of the cases. In some cases, relief has lasted eight and one-half months."

In the August, 1936, issue of the American Journal of Obstetrics and Gynecology, Maurice J. Meynier, Jr.,[5] of Houston, Texas, reports ten cases of pelvic carcinoma. In his summary he states "pain was markedly diminished in all cases except one. In the failure only a two per cent solution was used, which is an inadequate dose, and the patient refused a second injection."

It has been demonstrated by both of these articles that sensory nerves and particularly the pain fibers are more susceptible to the effects of alcohol than are the motor nerves. Hence, in the cauda equina where both motor and sensory nerves are close together only the sensory fibers are affected by the alcohol. This greater susceptibility of the pain and other sensory nerves to the effects of alcohol may be explained by the diminished amount of myelinization which these nerve fibers possess. It is also probable that even in the first lumbar interspace the motor nerves are reached by the alcohol but are not affected because of their heavier myelinization and lessened susceptibility.

My idea of the treatment of dysmenorrhea by the intraspinal injection of alcohol was obtained from these articles, but nowhere in the literature to date can I find where any cases of dysmenorrhea have been treated in this manner. If this treatment relieves carcinoma cases by decreasing the activity of the sensory fibers, why cannot it be expected to do the same in these cases of essential dysmenorrhea or, as further study and observation may show, in any type of dysmenorrhea.

I wish to report the following case:

White female, age 38 years. Menstrual history began at age of 13 years, regular every 28 to 30 days, duration 5-7 days, normal amount. At times the patient had had extreme dysmenorrhea and was confined to bed three or more days with abdominal cramps. She had had five pregnancies, all full term normal deliveries. I delivered the last child in October of 1925. In June of 1931 this patient came to me with the complaint of painful menstrual periods, heavy uncomfortable feeling in the back and lower

abdomen and headaches. Examination showed she had a relaxed perineum, third degree retroversion of the uterus but cervix in very good condition. On July 28, 1931, I operated on this patient, and did a dilatation and curettage, perineorraphy, Baldy-Webster suspension of the uterus, cut and ligated both tubes at the patient's request to prevent further pregnancies. The appendix had been removed at a prior operation. At the time of the operation a note was made on the operative record that the ovaries were slightly systic and sclerotic but otherwise normal. They were not molested. The operation apparently relieved the condition because I did not see the patient for several years except at long intervals and she had no complaint relative to her operation.

During 1935 I treated this patient for dysmenorrhea, using various sedatives, hot sitz baths and advising rest in bed during the period when necessary for pain. Her pains gradually became worse and the patient adopted the use of alcoholic beverages, including beer to the amount of eight and ten bottles daily for sedation.

On October 7, 1936, I saw this patient in the office relative to her dysmenorrhea and her pelvic check showed her uterus to be in good position, the cervix patent easily admitting a 20 French sound the entire length of the canal, no masses in either fornix, uterus normal in alignment and size and freely movable. There was some pain on bimanual palpation of the ovaries but they were normal in size and position.

I saw this patient again on October 14, 1936, when her premenstrual cramps were just beginning and she wanted a hysterectomy to prevent her from further pain. On October 17 this patient was in the office again, the second day of her menstrual cycle, and her pain was extreme. She was on the point of hysteria, crying, holding her abdomen, stamping her feet on the floor and begging for relief.

On October 17 at 8 p. m. I sent the patient to the hospital and did a spinal puncture in the fourth lumbar interspace. Five cc. of spinal fluid was withdrawn and a solution of ten cc. containing eight-tenths cc. absolute alcohol and 9.2 cc. of distilled water, was injected slowly into the dural cavity. The puncture was made with the patient lying on her side. Less than five minutes after the alcohol was injected the pain was relieved and the only sensation the patient noted was that of feeling as if something was "quivering" in the suprapubic region of her abdomen. She described the feeling as that similar to the gums after a novocaine injection for removal of a tooth.

The patient was kept in bed for four hours and then allowed to get up and go home. She stated that she had a headache for about three days and that her back and legs also ached, but the menstrual cramps and the bearing down pains stopped immediately and she began to "really flow."

She was asked to note any disturbance in her bladder and bowel function and to chart carefully the time of each for the next 24 hours and they were as follows: voided normally after returning home from the hospital and the next morning at 5:05 a. m., 7:40 a. m., 9:25 a. m., at noon, 5:05 p. m., 7:40 p. m., 9:45 p. m., and 10:30 p. m. on October 18. She slept through the night and voided at 6:15 a. m. and 8:35 a. m. on October 19. Her bowels moved normally at 7:30 a. m. the morning after the injection. She has had no disturbance of the bladder or bowel function since the injection was made. There has been no evidence of motor nerve disturbance. In November the patient took an automobile trip to Ohio and her period came on two days after her arrival, almost without her knowledge and she experienced no pain or inconvenience at all. The December and January periods were likewise normal and free from discomfort or pain. There has been no disturbance in her sexual life.

I fully realize that this one case report does not constitute an authority on this line of treatment, but it does offer food for thought. In this one case we can rule out pathology except for possible sclerotic ovaries, because the writer had the opportunity of seeing the pelvic organs at operation and the ovaries and uterus could be easily outlined on a pelvic examination. Since the cervix was well open and the uterus in good position we can rule out most of the pelvic abnormalities that are apparently a causative factor in dysmenorrhea. Frankly, I used the alcohol treatment on this patient because I had tried everything else and knew nothing else to do except a hysterectomy and, fortunately, it has seemed to give satisfactory results.

From the anatomical standpoint of this line of treatment, when it can be definitely found just what dilution of alcohol will affect the sensory nerves without producing any deleterious

effect on the motor nerves, the efficiency of the treatment can be improved and the duration of the beneficial results will be prolonged. In this case I used approximately a seven per cent solution of alcohol in distilled water.

Gross specimens of the lumbar or caudal nerve trunks could be obtained at autopsy, sections of the sensory and motor nerves subjected to varying solutions of alcohol for six or eight hours and the solution which would affect the sensory nerves without affecting the motor nerves could be accurately determined by microscopical section. The treatment, if successful in any series of cases, is simple to carry out and causes no inconvenience to the patient.

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ADDENDUM (May 10, 1937)

The patient whose case is cited has passed the February, March, April and May menstruations without any discomfort, thus making a total of eight menstruations since the alcohol injection was given.

EPIDEMIC CEREBROSPINAL MENINGITIS

(CEREBROSPINAL FEVER, SPOTTED FEVER, MENINGOCOCCUS MENINGITIS)

A Report of Forty Cases Treated at St. Luke's Hospital In Jacksonville, Fla., During the Years 1926 to 1936.

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The purpose of this paper is to give a brief resume of the history, epidemiology, symptomatology and treatment of epidemic cerebrospinal meningitis, and to present forty cases treated at St. Luke's Hospital in Jacksonville, Florida, during the past ten years, and the results with different forms of therapy.

Epidemic cerebrospinal meningitis is an infection of the meninges by the diplococcus intracellularis, a gram-negative diplococcus which gains entrance to the meninges through the nasopharynx or the blood stream. The disease is endemic in all parts of the country, and occurs occasionally in small epidemics. A number of epidemics occurred among the American troops during the World War. The disease usually strikes the newcomer to an area where the disease is endemic, or may become epidemic when a carrier comes into a group of people where the disease is not prevalent.

HISTORY

Although this disease must have existed for ages, the first accurate description of the disease is credited to Vieusseux of Geneva in 1805, and, independent of him, to Danielson and Mann, of Manchester, Massachusetts. North, of New York, published the first monograph of it in 1811. Weichselbaum observed the meningococci in the spinal fluid, and obtained them in pure cultures in 1877. Kolle and Wassermann experimented on animals with a meningococcic antibacterial serum in 1906. In the same year Jochmann injected the antiserum into patients with meningitis intraspinally. Simon Flexner in 1907, as a result of extensive laboratory and clinical research, firmly established the therapeutic value of antimeningococcic serum. In 1931 Ferry succeeded in producing a toxin from cultures of meningococci which produced the same symptoms in animals as the organisms themselves. He also found that he could immunize animals and obtain an antitoxin which would neutralize the toxin produced by the meningococci. Believing that the clinical symptoms of epidemic cerebrospinal meningitis are due to the toxin rather than the bacteria themselves, Hoyne used the antitoxin clinically in 1935 with remarkable results.

MODE OF ONSET AND CLINICAL FINDINGS

The mode of onset of epidemic cerebrospinal meningitis varies, but all cases fall more or less into three groups. One group of cases has symptoms of a mild upper respiratory infection for several weeks before the onset of the meningeal symptoms. The second group has symptoms of a more severe upper respiratory infection and the meningeal symptoms set in only a few days after the onset of the respiratory symptoms. The third group has no upper respiratory symptoms, but has a sudden onset of severe meningeal symptoms and the patients frequently die before treatment can be instituted.

Usually the first symptom is severe headache that does not respond to the ordinary household headache remedies. This is accompanied by insomnia, restlessness and followed by nausea

and vomiting. The neck then becomes painful and stiff, the eyes become painful and wall backwards. Rapidly there is developed opisthotonos and the whole spine is dorsoflexed and rigid. The temperature may go up to as high as 105°, but sometimes no higher than 100°-101°. A rash may develop over the body on the second day, but this is not a constant finding. Frequently there is delirium and convulsions.

Upon examination of the patient there is usually found a marked hyperesthesia over the whole body. All the reflexes are hyperactive, Babinski's reflex is positive, as is usually Kernig's sign. Not all cases have all of these symptoms and signs. In some cases the reflexes are hypoactive. Some patients, in whom encephalitis has set in, may be relaxed instead of rigid. There may be other complications such as deafness, blindness, otitis media and arthritis.

Examination of the spinal fluid usually shows cloudy fluid under increased pressure. In cases of long duration it may be impossible to obtain much spinal fluid because of a block in the spinal canal. The spinal fluid usually shows from 150 to 50,000 white cells per cmm., most of which are neutrophiles. The gram-negative diplococci are usually found both extracellularly and intracellularly, though they are frequently difficult to find. Generally speaking, the number of organisms found is not an index to the severity of the disease. Cultures properly made usually are positive for the diplococci intracellulare. The white blood cell count is usually between 15,000 to 35,000 with a relative granulocytosis.

TREATMENT

From June 10, 1926, to June 10, 1936, there were admitted to the Isolation Ward of St. Luke's Hospital in Jacksonville, Florida, a total of forty cases diagnosed as epidemic cerebrospinal meningitis. The cases are divided into four groups as follows:

Group I. Twelve patients admitted prior to July 1, 1935.

Group II. Five patients admitted since July 1, 1935, who died within eight hours following admission, and upon whom treatment could not be carried out.

Group III. Fifteen patients admitted since July 1, 1935, treated with meningococcus antiserum.

Group IV. Eight patients admitted since April 15, 1935, treated with meningococcus antitoxin.

Taking the forty cases as a whole the average duration of illness prior to admission was 5.5 days. The average admission spinal fluid cell count 8,360, and the average peak cell count 13,176 with an average increase in cell count of 5,000 following institution of treatment. The average days of treatment was 3.5 days; the average number of treatments 6.8; the average number of punctures 9.5. The average volume of serum and antitoxin used was 160 cc. per patient with an average cost to the patient of $44.00. The average period of critical illness following institution of treatment was 6.5 days. Of these forty patients nineteen died, giving a mortality rate of 47.5%. Excluding the five patients who died within eight hours after admission the mortality rate is 40%.

The worst results were obtained with the first group of twelve admitted prior to July 1, 1935. In this group, treated with meningococcus antiserum, ten out of the twelve patients died, a mortality rate of 83%. The explanation for this high mortality rate can readily be seen in the fact that these patients received an average of only five spinal punctures, and 40 cc. of serum. Of the two who did recover, one received 200 cc. and the other 150 cc. of serum, whereas the others received only an average of 15 cc. of serum each.

In the 28 cases admitted since July 1, 1935, which includes the last three groups, nine patients died, a mortality rate of 32.0%. If we exclude the five in Group II who died within 8 hours following admission, the mortality rate is only 17.3%.

The patients in Group II were all moribund on admission. Two were negro girls, aged 9 and 14, and were ill only 12 and 36 hours, respectively, when admitted. All of this group died within one to eight hours following admission, before treatment could be carried out.

The fifteen patients in Group III all received antimeningococcic serum intraspinally every eight hours and intravenously every 24 hours until improvement was shown, when the intravenous treatment was discontinued and the serum was given intraspinally every 12 hours. Later the serum was given every 24 hours and when sufficient improvement was shown, both clinically and in the spinal fluid count, the spinal canal was drained every 12 to 24 hours and no serum was given. When the spinal fluid cell count reached a low level and maintained this low level along with clinical improvement spinal punctures were

discontinued. There was some modification of this routine in several cases. In two cases cysterna punctures had to be resorted to because no fluid could be obtained from the spinal canal. This group of patients received an average of 340 cc. of antimeningococcic serum at a cost of $95.50 per patient. The average number of treatments was 16 and each patient had an average of 20 spinal punctures. The average admission spinal fluid cell count was 15,615, with an average rise in cell count to 29,540. The average increase in the spinal fluid cell count following institution of treatment was therefore 13,900. These patients were, on the average, critically ill for eight days following institution of treatment. Of these fifteen patients, three died, giving a mortality rate of 20%. One patient had an enucleation of one eye because of a panophthalmia on admission. Four of the patients were either partially or entirely deaf on admission and did not recover their hearing. One patient had a severe respiratory depression following the repeated administration of a fourth of a grain of morphine within two hours of each other. This patient recovered following artificial respiration for about two hours.

There were eight patients in Group IV, all of whom were treated with meningococcic antitoxin. One of these patients, with a rather mild case, who came in within 24 hours after the onset of his symptoms received only 30,000 units or 90 cc. of antitoxin intravenously on admission and none intraspinally. He responded with relief of symptoms and drop in cell count within 24 hours. He had an uneventful recovery without further treatment. Six patients received 90 cc. intravenously and 30 cc. intraspinally upon admission. In four cases this had to be repeated 24 to 48 hours later. One two-year-old child received 40 cc. intravenously, 20 cc. intraspinally with rapid uneventful recovery. The average volume of antitoxin administered was 160 cc. at a cost of $36.00 per patient. The average number of treatments per patient was 2.5 and an average of seven spinal punctures per patient. In one case cysternal puncture had to be resorted to. The average time the patients were critically ill following institution of treatment was four days. The average spinal fluid cell count on admission was 9,600 with an average rise to 11,100 or an average increase of 1,500 in the cell count following institution of treatment. Of the eight patients treated with antitoxin one died and seven recovered, giving a mortality rate of 12.5%. The patient who died was moribund on admission and died 24 hours later. Only one patient had any complications. This patient had been ill for three weeks prior to admission. On admission he was unconscious and had a marked encephalitis with a left sided paralysis of the face and flaccid paralysis of his extremities. His spinal fluid was coagulated and too thick to be drained by lumbar puncture. Cysternal puncture was resorted to. He had to be fed by nasal feeding tube, through which he was fed frequently with a liquid diet containing an abundance of carbohydrates, proteins and fats as well as all essential vitamins. This patient regained consciousness, regained use of his extremities, his power of speech and was able to swallow when discharged.

In all cases the supportive treatment was watched diligently. Fluids were forced on all patients. Hypodermoclysis and venoclysis were resorted to when patients would not take sufficient amounts by mouth. Morphine was administered sparingly in small doses. Nembutal was used with much better results than morphine. When patients became restless or complained of severe headache, spinal drainage brought quicker relief than any drug. It is unwise to adhere strictly to one routine. Some patients require drainage of spinal fluid more frequently than others. Serum reactions were frequently encountered. The patients were watched for serum reaction and with each dose of serum or antitoxin adrenalin was administered.

SUMMARY

1. The history, epidemiology, and symptomatology of epidemic cerebrospinal meningitis is reviewed.

2. The experience with 40 cases in the contagious ward of St. Luke's Hospital in Jacksonville, Florida, during the past ten years is reported.

Out of the forty patients, the total mortality rate was 47.5%.

Out of twelve patients inadequately treated with antimeningococcic serum from June, 1926, to June, 1935, ten died, a mortality rate of 83%.

Five patients admitted since June, 1935, died within eight hours after admission and before treatment could be instituted.

Fifteen patients were thoroughly treated with antimeningococcic serum with a reduction in mortality rate to 20%.

Eight patients were treated with meningococcic antitoxin with a further reduction in mortality rate to 12.5%, the one death taking place in 24 hours.

Supportive treatment and frequent spinal drainage is stressed.

CONCLUSION

1. Thorough treatment with antimeningococcic serum produces a marked reduction in the mortality rate in epidemic cerebrospinal meningitis.

2. Treatment with meningococcic antitoxin has the following advantages over treatment with antimeningococcic serum: further reduction in mortality rate; more economical; reduces period of illness; reduces length of treatment; reduces number of spinal punctures; quicker drop in spinal fluid cell count.

3. Thorough supportive treatment and frequent spinal drainage is of great importance in the treatment of cerebrospinal meningitis.

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SURGERY IN THE TREATMENT OF PULMONARY TUBERCULOSIS*

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Perhaps nothing has been more marked among the advances of the twentieth century in surgery than the development of methods whereby this branch of the profession may serve in the battle against tuberculosis of the lungs. A few years ago it was estimated that 625,000 persons were suffering from pulmonary tuberculosis in this country alone, 85,000 of whom were dying annnually. The declining death rate each year has no doubt decreased this number considerably, but there still remains a formidable toll taken annually from our ranks by this dread disease. With the application of modern surgical methods to the treatment of tuberculosis, many of these unfortunates, who would otherwise be doomed to an early death, are being sent back to their homes and often into useful occupations.

*Read before the Annual Conference, Florida Tuberculosis and Health Association, Orlando, April 2, 3, 1935.

The primary factor in the treatment of tuberculosis is rest. Obviously, then, when the lung is the part of the body affected, rest for this organ becomes the desired objective. In tuberculosis of the hip, it is possible to stiffen or fuse the hip joint by operation and stop it from moving. This procedure gives the maximum rest to the joint and allows the body to combat the disease. Accordingly, in treating pulmonary tuberculosis it becomes desirable to stop the movements of the lung incident to respiration. Of course, we cannot completely stop both lungs from moving with respiration. What we can do, however, is to collapse the involved portion of the lung and put it at rest, thus allowing the body to combat the disease in the affected area. This process is known as collapse therapy and is the basis of surgical treatment of pulmonary tuberculosis.

Tuberculosis of the lungs usually starts in the upper portion, the apex, of one lung, and is for a short time, at least, confined to a small area. In many persons the resistance of the body is sufficient to wall off the initial lesion and heal it, roentgen study later showing only the small scar of a healed tubercle. In numbers of cases, however, the disease progresses involving more and more of the lung, and it usually eventually invades the other lung also. Early cases will frequently respond to the simple treatment of rest in bed at home or in a sanatorium. Unfortunately, few cases are diagnosed early enough. All too often destruction of a portion of a lung with the formation of cavities has taken place before the disease is diagnosed. Realizing that in many cases the disease will progress even under treatment of rest in bed, many authorities are advocating the early employment of collapse therapy in all cases except the very early ones and those so far advanced as to appear hopeless. We believe that future progress in the treatment of pulmonary tuberculosis will be made through earlier and more extended use of collapse therapy.

It has been aptly said that "in the vast majority of instances the prognosis in pulmonary tuberculosis is the prognosis of cavitation."[1] In a study of 1,454 cases showing cavitation admitted to the Rhode Island State Sanatorium between 1905 and 1927, Barnes and Barnes[2] observed that 80 per cent of these patients died within one year after admission and that the average duration of life was slightly over twelve months. Only one of the 57 colored patients survived

three years. A study by Sprungmann[3] of 626 cases of untreated cavitation in industrial workers over a period of sixteen years, showed a total mortality of 78.2 per cent and a death rate of 61.7 per cent for the first two years. Of the surviving group 69.1 per cent were totally or partially disabled.

What, then, is the answer to this problem of lowering the mortality from cavity? How are we going to prevent the formation of cavities in those early cases in which the patients do not show definite signs of improvement after a short period of rest in bed? The answer lies, we think, in two directions: first, in early diagnosis; and second, in the early and extended use of collapse therapy by one of the several means now at our disposal or, if necessary, by a combination of some of them. Pollock and Marvin[1] in discussing bilateral artificial pneumothorax stated: ". . . cavitation of large size or multiple in character, regardless of type, . . . will produce death if untreated by collapse therapy. . . . Unilateral involvement in the young adult should be treated by collapse therapy even when there is no cavitation, . . . and should be carried out early."

I know of no part of the United States in which the treatment of pulmonary tuberculosis is more thoroughly or more successfully carried out than in the state of Michigan. In 1933 Leslie[4] reported that of 420 consecutive admissions to the Michigan State Sanatorium from June 1, 1930, to March 29, 1932, 324, or 77.14 per cent, were selected for collapse therapy. Of this group 253, or 78.09 per cent, received one or more surgical operations other than pneumothorax.

Collapse therapy utilizes a number of procedures. The first of these is pneumothorax, with which most of you are probably familiar. Artificial pneumothorax is produced by the injection of air between the chest wall and the lung. The presence of the air prevents expansion of the lung with respiration and puts it at rest. This procedure is routinely carried out in the sanatorium and does not require special surgical training or technique. In many cases artificial pneumothorax, if maintained over a sufficient period, is all the treatment that is necessary. Of the 324 cases studied by Leslie[4] in which collapse therapy was the form of treatment, 16.9 per cent did not need additional surgery.

Unfortunately, collapse of the lung by artificial pneumothorax is not always possible because of adhesions between the two layers of the pleura, which attach the lung to the chest wall and prevent it from becoming collapsed. Not infrequently they hold open a cavity, making its collapse by air wholly impracticable. When the adhesions are in the form of strings or thin bands, it is often possible to insert an instrument called the thoracoscope into the chest between the lung and the chest wall. The thoracoscope closely resembles the cystoscope, used in looking into the bladder. Through the thoracoscope the operator is able to see the adhesions. A small cautery or electric knife is then inserted into the chest either through the thoracoscope or through another opening and the adhesions are burned in two. This procedure, called intrapleural pneumolysis, frees the lung and allows it to collapse.

Instead of using the thoracoscope, some surgeons prefer to make an incision in the chest wall over the region of the adhesions, remove a portion of a rib in this area, open the pleural cavity, and cut the adhesions under direct vision. This operation is known as open pneumolysis. Unfortunately, these wounds often show a tendency to heal poorly, and an opening into the chest sometimes persists in not healing, necessitating later the use of thoracoplasty.

There are several methods of collapse which do not necessitate the use of artificial pneumothorax. They are operative procedures and fall in the province of the thoracic surgeon. The first of them is the surgical interruption of the phrenic nerve, known variously as phrenic crush, phrenicectomy, phrenic avulsion and phrenicoexeresis. The diaphragm is a sheet-like muscle which forms the base of the chest cavity and upon which the lungs rest. When inspiration takes place, the diaphragm descends, allowing the lung to expand. The phrenic nerves supply the diaphragm. They arise in the neck and run down in front of the scalene muscles, the deep muscles of the neck, on through the chest to the diaphragm. There are two of these nerves, one controlling either side of the diaphragm. Interrupting the nerve surgically on one side will cause a paralysis of the diaphragm on that side. The diaphragm rises in the chest after being paralyzed, and the volume and motion of the corresponding lung are thus considerably diminished. Operations upon the phrenic nerve are not dangerous when properly performed and the mor-

tality is practically nil. A small incision is made in the neck under local anesthesia and the nerve is dissected out where it crosses the deep muscles. If it is desired to paralyze the diaphragm permanently, a portion of the nerve is pulled out. Frequently it is intended to paralyze the diaphragm for a short period of time only, and in that event the nerve is merely crushed with a clamp. Paralysis for about six months results.

Temporary paralysis of the diaphragm is especially valuable in cases of early tuberculosis where one wishes to aid the lung as much as possible but does not feel justified in using artificial pneumothorax. Operations upon the phrenic nerve are in many respects less radical procedures than artificial pneumothorax. It is rather surprising that although the diaphragm is located at the bottom of the lung, most of the collapse after paralysis occurs at the apex. This fact makes this operation very valuable indeed in the closure of small early cavities which have thin walls. O'Brien[5] reported the closure of as many as 50 per cent of cavities by phrenic operation alone. It is often effective to combine phrenic interruption with pneumothorax where adhesions prevent adequate collapse with air alone.

Another great field for phrenic operation is in cases where disease is present in both lungs. It is then the custom to try pneumothorax on the worse side and later perform a phrenic operation for the other side. In many clinics this procedure is regularly followed for bilateral tuberculosis.

Some thoracic surgeons believe that by cutting the scalene muscles, which arise high up in the neck and attach to the first rib, the apex of the lung is allowed to descend, thus possibly having some beneficial collapsing effect upon the diseased area. This procedure is known as scaleniotomy. There is a good deal of question, however, as to its real value. Another operation which can sometimes be used to advantage where the presence of adhesions prevents collapse is called extrapleural pneumolysis. In this procedure the outer layer of the pleura is dissected off from the inside of the chest wall, and paraffin, fat, muscle or some other foreign body is used to fill the space thus made and push down the lung. The objection to this operation is that it requires the use of a foreign body, the employment of which should be avoided wherever possible.

Unfortunately, there is a large number of cases of tuberculosis with cavity formation in which the cavities cannot be closed by pneumothorax because of adhesions and in which phrenic interruption is not satisfactory. These cavities can only be closed by a plastic operation on the chest wall itself. Thoracoplasty is a serious and major surgical operation and requires much more technical skill on the part of the surgeon than any of the procedures of collapse therapy already mentioned. Thoracoplasty consists in the removal of a portion or all of the ribs overlying a diseased lung. Since the lung itself tends to collapse as soon as the supporting action of the ribs is removed, it is not necessary to apply pressure to the de-ribbed area in order to obtain collapse. Thoracoplasty is thus a relaxing procedure and allows the portion of lung collapsed to come to a complete rest, thereby providing the ideal condition for healing the disease.

When we speak of thoracoplasty, most of us immediately think of an extensive, shocking operation in which large segments of many ribs are removed at one time leaving deformity of the chest. It is true that some of the earlier operations were quite extensive and accompanied by much shock, and in many of them the patient was left with a noticeable deformity. Use of the present technique of selective, multi-stage thoracoplasty eliminates these objections. Formerly, it was the custom to remove portions of all the ribs in one or two operations, causing collapse of the whole lung even though less than half of it may have been diseased. Recently, however, this conception has changed and thoracic surgeons are endeavoring to collapse only that portion of the lung which contains the cavity to be closed. Since in most cases only the upper portion of the lung is involved, the newer technique consists in removing the first two or three ribs completely at the first operation. A period of from three to six weeks is allowed to elapse and then further removal of ribs is done according to the findings of the roentgen study. This operation is called selective thoracoplasty and does two things. First, it decreases tremendously the shock and deformity following thoracoplasty. Second, it collapses only that portion of the lung which is diseased and does not needlessly sacrifice the healthy part. When this operation is performed by trained thoracic surgeons, the mortality need not be more than from

5 to 10 per cent. This rate compares favorably with that of many abdominal operations.

The development of this selective, multi-stage type of operation has done much to popularize the use of thoracoplasty and has undoubtedly made possible the collapse of diseased portions of the lung in patients who would not ordinarily be strong enough for a more extensive operation. Also, it is possible to use this type of operation even when some disease is present in the opposite lung. It has sometimes been found that collapse of the worse lung is often immediately followed by a favorable change in the other lung. This observation, of course, is not new since it has long been known that after collapse of the worse lung with pneumothorax there is often a striking benefit to the other side. In at least one or two cases a small selective thoracoplasty has been done on both sides for bilateral cavitation. It is probable that, with wider knowledge of the advantages of this type of operation, the indications for its use will be extended.

A study of the results in a large number of cases of thoracoplasty shows that from five to seven years after operation, between 25 and 60 per cent of the patients are well and back at their former occupations and from 15 to 30 per cent more are considerably improved, probably enough to live at home with limited activities. Of course, these results are far from perfect, but one must remember that according to the statistics already quoted, in about 90 per cent of these cases of cavitation the patients would have been dead in less than five years without operation. There is no doubt that, with the more extended use of multi-stage thoracoplasty, these results will be considerably improved upon.

A word may be added about the use of surgery in pulmonary tuberculosis among the colored race. Most of us will admit that this race does not have the resistance to tuberculosis that the white race possesses. This lack of resistance is certainly true of the southern Negro though reports from some northern clinics seem to indicate that it is not true there. I think it has already been proven that the early and extended use of collapse therapy will do much to prevent the rapid spread of this disease, the incidence of which is markedly high in the colored race. Pneumothorax and operation upon the phrenic nerve are the most valuable procedures with this race, but thoracoplasty can also be used in many cases with favorable results.

It must be emphasized that surgery is only an aid in the whole program of treatment of tuberculosis and that the surgeon must work hand in hand with the medical man in determining a program of collapse therapy for the particular case to be treated. For this reason it is better for the surgical treatment of pulmonary tuberculosis to be carried out whenever possible in a sanatorium where the surgeon is an active member of the staff. Cases which seem to need collapse therapy should be passed upon at a conference between the internist, the roentgenologist and the surgeon.

CONCLUSIONS

Cavitation in tuberculosis of the lungs is a definite indication for collapse therapy. Early collapse of non-cavity lesions will do much to prevent the formation of cavities and to reduce the high mortality in cases showing cavitation.

Artificial pneumothorax is our chief aid in collapse therapy. Unfortunately, adhesions often prevent its satisfactory use.

Pleural adhesions may sometimes be severed by the thoracoscope or by open operation.

Phrenic interruption is of inestimable value as an aid in the control of early lesions. It is also valuable in bilateral disease and in closing small cavities.

For cavities which resist simpler methods of collapse, thoracoplasty is a logical and successful procedure in numerous cases. It should be selective and many-staged in type.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

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POSTGRADUATE SHORT COURSE

The Fifth Annual Graduate Short Course for Doctors of Medicine in Florida will be held in Orlando, June 21 through 26. Elsewhere in this Journal will be found interesting data regarding the courses presented and the men who offer them. The committee in charge of arranging this program deserves an enormous amount of credit for presenting to our Florida profession a course which could not be duplicated except by far greater expenditure of both time and money than will be required of those attending the course.

With the exception of the symposium on tuberculosis Tuesday afternoon and night, June 22, all sessions of the short course will be held in the auditorium of the Orange Court Hotel, Orlando. Inasmuch as the hotel is making attractive rates, this will be a great convenience to physicians attending.

The short course is presented under the joint auspices of the Florida Medical Association and the University of Florida. Those attending the various sessions always have been most enthusiastic about the opportunities offered. The instructors on the programs often have attended the lectures of other instructors and their comments on the general character of the course have invariably been most complimentary.

SHORT COURSE SYMPOSIA

As in former years two evenings of the Short Course will be given over to symposia. On Tuesday, June 22, the afternoon schedule will be shortened so that doctors attending the course may have the opportunity of visiting the new State Tuberculosis Sanatorium at Woodsmere, a few miles out of Orlando. From 5:00 to 6:30 o'clock will be devoted to the inspection of the institution and to the demonstration of artificial pneumothorax. After a buffet supper at the sanatorium, a symposium on tuberculosis will be presented at 7:30.

The principal address of the symposium will be "Trends of Surgical Treatment in Pulmonary Tuberculosis" by Dr. Pol N. Coryllos. Dr. Coryllos is professor of Clinical Surgery at Cornell University Medical College and Clinical Professor of Thoracic Surgery at New York Polyclinic Medical School and Hospital. He will be heard again at luncheon on Wednesday, June 23, his subject at that time being "The Surgical Management of Pulmonary and Pleural Tuberculosis".

Dr. R. D. Thompson, Superintendent of the State Tuberculosis Sanatorium will take up "The Value of Sanatorium Care of the Tuberculous Patient". Dr. Thompson comes to Florida from Wisconsin, where he has been Superintendent of the Wisconsin State Sanatorium since 1929, having previously held a similar position at the Kalamazoo County Sanatorium, Kalamazoo, Michigan.

"The Transitory Stage in Childhood Tuberculosis" will be discussed by Dr. T. M. Palmer. Long identified with the fight against tuberculosis, Dr. Palmer is at present a member of the Board of Directors of the Duval County Tuberculosis Association and consultant on childhood tuberculosis at the Duval County Hospital.

On Friday evening, June 25, at 7:30 o'clock, a symposium on neurosurgery will be presented. Dr. C. C. Coleman will have two 45-minute talks, the first on "The Management of Acute Craniocerebral Injuries" and the second on "The Treatment of Spinal Cord Lesions: (a) Injuries, (b) Tumors". Dr. Coleman is Professor of Neurological Surgery at the Medical College of Virginia, Richmond.

Dr. J. G. Lyerly, who will discuss "Surgical Procedures for the Relief of Pain", was formerly associated with Dr. Coleman in Richmond and is now Neurosurgeon on the staffs of several Jacksonville hospitals.



WALTER L. BIERRING

DR. BIERRING TO GIVE LECTURES ON MEDICINE

Dr. Walter L. Bierring, President of the American Medical Association in 1934-35, consented to come to Florida in June to present the course in Medicine at the Short Course for Doctors. After his graduation from the Iowa State University College of Medicine in 1892, Dr. Bierring continued his studies at the University of Vienna, University of Heidelberg, and the Pasteur Institute in Paris until 1901, paying special attention to pathology, bacteriology, and internal medicine. He was Professor of Pathology and Bacteriology at the University of Iowa from 1893 to 1903 and Professor of Theory and Practice of Medicine and Clinical Medicine at the same institution from 1903 to 1910. He was Professor of Theory and Practice of Medicine at Drake University Medical School until it merged with the University of Iowa in 1914.

From 1914 to 1921, Dr. Bierring served on the Iowa State Board of Health and Medical Examiners. Since 1916 he has been a member of the National Board of Medical Examiners, being president from 1928 to 1930. He became a Fellow of the American College of Physicians in 1929 and Regent in 1930.

Dr. Bierring was elected an honorary member of the Royal College of Physicians, Edinburgh, in 1921. He was a member of the Commission to Study Medical Education and Qualifying Methods in France and Great Britain, a member of the Commission on Medical Education, and a member of the Medical Advisory Board, Commission on Economic Security. He has held offices in the American Medical Association since 1905, his career in that organization culminating with the presidency in 1934 and 1935. Since July 1, 1933, he has been Iowa State Commissioner of Health. In 1936 he became chairman of the American Board of Internal Medicine.

TEMPLE'S DR. ARNOLD FOR OBSTETRICS

Presenting the course in Obstetrics at the Short Course in June will be Dr. J. O. Arnold, Professor of Obstetrics at Temple University Medical School. Dr. Arnold graduated from Jefferson Medical College in 1896. For seven years following graduation he was clinical instructor at Jefferson Medical College. In 1904 he joined the teaching staff of the recently organized medical school of Temple University where he was successively Instructor, Associate Pro-



J. O. ARNOLD

fessor, Clinical Professor, and, in 1927, Professor and head of the Department of Obstetrics.

Dr. Arnold is the author of a "Guide-Book in Practical Obstetrics" published in February, 1937, for hospitals and general practitioners, the "Temple Treatment" of Eclampsia, several series of "Obstetrical Review Clinics", and numerous other papers on obstetrics.

Many delivery room and other obstetrical instruments have been devised by Dr. Arnold, such as "Arnold Induction Tubes", "Cord Clamps", "Aspirator", "Obstetrical Forceps", etc.

DR. SCHAFFER OF JOHNS HOPKINS TO GIVE PEDIATRICS COURSE

Dr. Alexander J. Schaffer, who will present the course in Pediatrics at the Short Course in June, graduated from Johns Hopkins School of Medicine in 1923. He was house officer at Harriet Lane Home, 1923-24; assistant resident, 1924-25; resident, 1925-26. He was chief dispensary pediatrician from 1926 to 1927. In 1925 he became Instructor in Pediatrics at Johns Hopkins School of Medicine, which position he held until 1936 when he became Associate Professor in Pediatrics.

Included among Dr. Schaffer's publications are "Treatment of Erysipelas with Blood Transfusion" and "Mikulicz' Syndrome", both of which appeared in the *American Journal of Diseases of Children* in 1927, "A Study of the Value of Convalescent's Serum in the Prevention of Measles", *Bulletin of the Buffalo General Hospital,* 1928, "Uveoparotid Fever as a Manifestation of Mikulicz' Syndrome", *American Journal of Diseases of Children,* 1928, "Etiology of Infantile Acquired Hemiplegia" with Dr. Frank Ford, and "Chronic Pyelo-Nephritis".

DR. CARTER TO LECTURE ON GYNECOLOGY

The lectures on Gynecology at the June Short Course will be given by Dr. Bayard Carter of Duke University. Following three years in the Honour School of Physiology at Oxford University, England, Dr. Carter returned to Baltimore and completed his medical course at Johns Hopkins School of Medicine in 1925. After taking postgraduate work at Yale University, he became head of the Department of Obstetrics and Gynecology at the University of Virginia. In 1931 he went to Duke University as Professor of Obstetrics and Gynecology.

Dr. Carter is a member of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons; the American Board of Obstetrics and Gynecology; and Associate Examiner in Obstetrics and Gynecology for the National Board of Medical Examiners.



RALPH GREENE

DR. GREENE ON FACULTY

Familiar to Florida doctors is Dr. Ralph N. Greene, who will present the Neuropsychiatry course at Orlando in June. At present Medical Director of Eastern Air Lines, Dr. Greene was formerly chief of the medical staff of Florida State Hospital and, later, attending neurologist at Duval County Hospital and St. Luke's Hospital in Jacksonville. He is now Neurological Consultant, Bureau of Air Commerce, United States Department of Commerce, a member of the American Neurological Society, and former fellow of the American Society of Psychiatrists.

In 1917 Dr. Greene was elected president of the Florida Medical Association. He is also a past president of the Aero Medical Society of the United States.

	Monday June 21	Tuesday June 22	Wednesday June 23	Thursday June 24	Friday June 25	Saturday June 26
8:00 a. m.	8:00–9:00 REGISTRATION Orange Court Hotel Orlando					
9:00 a. m.	9:00–10:00 PEDIATRICS "Infant Feeding and the Avitaminoses" Dr. SCHAFFER	9:00–10:00 PEDIATRICS "Infantile Tuberculosis" Dr. SCHAFFER	9:00–10:00 PEDIATRICS "Modern Serotherapy and Chemotherapy" Dr. SCHAFFER	9:00–10:00 GYNECOLOGY "Infections of the Vagina, Cervix and Vulva" Dr. CARTER	9:00–10:00 GYNECOLOGY "Endometriosis" Dr. CARTER	9:00–10:00 GYNECOLOGY "Backache in the Female" Dr. CARTER
10:00 a. m.	10:00–11:00 NEURO-PSYCHIATRY "Examination of the Neurological Patient" Dr. GREENE	10:00–11:00 NEURO-PSYCHIATRY "Syphilis of the Central Nervous System" Dr. GREENE	10:00–11:00 OBSTETRICS "Revising the Code of Prenatal Care" Dr. ARNOLD	10:00–11:00 SURGERY "Diseases of the Breast" Dr. BURNETT	10:00–11:00 SURGERY "Diseases of the Colon, Rectum and Small Intestine" Dr. BURNETT	10:00–11:00 SURGERY "Infections and Surgical Emergencies" Dr. BURNETT
11:00 a. m.	11:00–11:30 RECESS	11:00–11:30 RECESS	11:00–11:30 RECESS	11:00–11:30 RECESS	11:00–11:30 RECESS	11:00–12:00 OBSTETRICS "Fluid-Balance and Dehydration in the Control of Eclampsia" Dr. ARNOLD
11:30 a. m.	11:30–12:30 MEDICINE "Cardiac Arrhythmias" Dr. BIERRING	11:30–12:30 MEDICINE "Digitalis—When to Use It" Dr. BIERRING	11:30–12:30 MEDICINE "Diabetes and the New Insulin" Dr. BIERRING	11:30–12:30 OBSTETRICS "Labor Analgesics" Dr. ARNOLD	11:30–12:30 OBSTETRICS "Operative Deliveries and Some of Their Dangers (Forceps, Versions, Cesareans, etc.)" Dr. ARNOLD	12:00–1:00 SURGERY "Minor Surgical Office Procedures" Dr. BURNETT
12:30 p. m.	12:30–2:00 LUNCH	12:30–1:30 LUNCH	12:30–2:00 LUNCH	12:30–1:30 LUNCH	12:30–2:00 LUNCH	
1:30 p. m. or 2:00 p. m.	2:00–3:00 NEURO-PSYCHIATRY "Diseases of the Peripheral Nerves and of the Spinal Cord" Dr. GREENE	1:30–2:30 NEURO-PSYCHIATRY "Diseases of the Brain; Traumatic Lesions of the Brain and Spinal Cord" Dr. GREENE	2:00–3:00 NEURO-PSYCHIATRY "Neurological Diseases of General Origin" Dr. GREENE	1:30–2:30 SURGERY "Diseases of the Gall Bladder and Diseases of the Appendix" Dr. BURNETT	2:00–3:00 SURGERY "Gastric and Duodenal Ulcer, Gastric Malignancy" Dr. BURNETT	
2:30 p. m. or 3:00 p. m.	3:00–3:15 RECESS	2:30–2:40 RECESS	3:00–3:15 RECESS	2:30–2:40 RECESS	3:00–3:15 RECESS	
2:40 p. m. or 3:15 p. m.	3:15–4:15 MEDICINE "Vascular Hypertension" Dr. BIERRING	2:40–3:40 MEDICINE "The Anemias" Dr. BIERRING	3:15–4:15 MEDICINE "The Art of Clinical Diagnosis" Dr. BIERRING	2:40–3:40 GYNECOLOGY "The Conservative Treatment of Pelvic Infections" Dr. CARTER	3:15–4:15 GYNECOLOGY "Special Diagnostic Measures in Gynecology" Dr. CARTER	
3:40 p. m. or 4:15 p. m.	4:15–4:30 RECESS	3:40–4:40 PEDIATRICS "Hazards of the Neo-Natal Period" Dr. SCHAFFER	4:15–4:30 RECESS	3:40–4:40 NEURO-PSYCHIATRY "The Problem of the Nervous Breakdown" Dr. GREENE	4:15–4:30 RECESS	
4:30 p. m. or 5:00 p. m.	4:30–5:30 PEDIATRICS "Urinary Infections and Nephritis" Dr. SCHAFFER	5:00–6:30 INSPECTION OF NEW TUBERCULOSIS SANATORIUM AT WOODSMERE "Demonstrations of Artificial Pneumothorax"	4:30–5:30 OBSTETRICS "Prophylactic Problems of the Ante-Natal Life" Dr. ARNOLD	5:00—on ANNUAL BARBECUE, ORANGE COUNTY MEDICAL SOCIETY (Place to be announced)	4:30–5:30 OBSTETRICS "The Occiput Posterior and Other Common Causes of Dystocia" Dr. ARNOLD	
6:30 p. m.		6:30–7:30 BUFFET SUPPER AT SANATORIUM				
7:30 p. m.		7:30—on SYMPOSIUM ON TUBERCULOSIS "Trends of Surgical Treatment in Pulmonary Tuberculosis" Dr. CORYLLOS "Transitory Stage in Childhood Tuberculosis" Dr. PALMER "Value of Sanatorium Care for the Tuberculous Patient" Dr. THOMPSON			7:30–9:30 SYMPOSIUM ON NEUROSURGERY "Management of Acute Cranio-cerebral Injuries" (45 min.) Dr. COLEMAN "Surgical Procedures for the Relief of Pain" (20 min.) Dr. LYERLY "Treatment of Spinal Cord Lesions: (a) Injuries; (b) Tumors" (45 min.) Dr. COLEMAN	

DR. W. E. BURNETT FORMER FLORIDA PHYSICIAN TO PRESENT SURGERY COURSE

Many Florida physicians will remember Dr. W. E. Burnett, East Coast Railroad surgeon from 1928 to 1930, who is scheduled to give the lectures on Surgery at the Short Course. Following his graduation from Jefferson Medical College in 1923 and his internship of two and a half years he spent six months doing postgraduate work in Vienna, Paris, London, and Edinburgh. At present he is Assistant Professor of Surgery, Temple University Medical School and Associate Surgeon at Temple University Hospital and Philadelphia General Hospital. He is a member of the American College of Surgeons.

Dr. Burnett's publications include six articles in the *Cyclopedia of Medicine,* (F. A. Davis Company), "Serum Treatment of Gas Gangrene", *Pennsylvania State Medical Journal,* 1932, "Rectal Drainage of Pelvic Abscess in Males", *Surgical Clinics of North America,* 1934, "Treatment of Perforative Appendicitis", *Delaware State Medical Journal,* 1934, and "One-Stage Pneumonectomy under Local Anesthesia", *American Journal of Thoracic Surgery,* 1937.

STATE NEWS ITEMS

Dr. L. M. Anderson of Lake City was recently appointed Inspector of State Institutions and Administration Advisor, by the State Board of Health. Doctor Anderson has had many years experience in the medical field, including preventive medicine. His headquarters are now in Jacksonville.

* * *

Dr. William S. Manning who is lieutenant-colonel of the Medical Corps Reserve, was recently reelected as president of the Jacksonville Chapter, Reserve Officers' Association, United States Army. This is Doctor Manning's second term in this position.

* * *

The offices of Dr. A. Boynton Wilber are now located at 170 Sea View Avenue, Palm Beach. For several summers past, Doctor Wilber has studied in Vienna, Budapest and Paris.

* * *

Dr. T. Z. Cason of Jacksonville was one of the new members named on the board of governors of the American College of Physicians, meeting in St. Louis in its twenty-first annual convention, according to an Associated Press dispatch.

Dr. Edward Jelks, president of the Florida Medical Association, and Dr. J. G. Lyerly, both of Jacksonville, were guests of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society at its quarterly meeting held recently in Chattahoochee.

* * *

Dr. and Mrs. W. E. Murphree of Raiford announce the birth of a daughter, Mary Catherine, on April 27 at St. Lukes Hospital, Jacksonville.

* * *

Dr. J. P. Tomlinson, Jr., of Lake Wales, and Dr. J. L. Hargrove of Bartow attended the Southeastern Surgical Congress in Charlotte, N. C., March 8-10.

* * *

The Florida Tuberculosis and Health Association held its annual conference on tuberculosis in Miami, May 3 and 4 at the Marine Root Columbus Hotel. The Committee on Tuberculosis and Public Health of the Florida Medical Association with Dr. M. Jay Flipse chairman, and the State Tuberculosis Board with Dr. W. T. Edwards chairman, met in conjunction with the Florida Tuberculosis and Health Association.

* * *

Dr. Henry Hanson, formerly State Health Officer of Florida and still a member of the Florida Medical Association, wrote recently that Dr. Richard P. Strong of the Harvard School of Tropical Medicine is in Peru. A study is being made of the Verruga Peruana, apparently the only disease which has a definitely limited distribution; it is found only in Peru and there only within certain limited altitudes, as well as latitude and longitude.

Doctor Hanson is planning a trip to the eastern slope of the Andes, in the Chanchamayo valley, where the Peruvian Corporation has requested him to study the incidence of malaria on their coffee plantations. He hopes to have the plague sufficiently under control to allow him to make this survey and control study. He reports that the cooler weather has already set in at Lima and they are beginning to wear winter clothes.

* * *

Dr. Gerry R. Holden of Jacksonville addressed the semi-annual meeting of the Eighth District Medical Society of Georgia, which was held at Camp Marion, St. Simons Island, during the middle of April. He discussed "Cancer as a Problem of Public Health."

Dr. J. G. Lyerly of Jacksonville attended the Cushing Society Meeting in Philadelphia, May 6-8, where he read a paper on "Meningioma of the Lateral Ventricle."

* * *

Dr. Carlos P. Lamar and Miss Celita Fernandez Renedo were married April 24 at the residence of Dr. J. M. Renedo, the bride's uncle, in Miami. Dr. Lamar, formerly of Havana, Cuba, has been a resident of Miami for several years and has offices in the Ingraham Building.

* * *

The engagement of Dr. Carl S. Lytle of Dunnellon and Miss Carolyn Endsley of Brooksville was recently announced. The marriage will be an event of the late spring.

* * *

Dr. and Mrs. Irby Black of Jacksonville announce the birth of a daughter, Joan Adair, on April 22.

* * *

Dr. L. E. Bransford of Jacksonville recently moved his offices to 28 West Monroe Street, where he will confine his practice to neoplastic diseases.

SAMUEL C. WOOD

Dr. Samuel C. Wood, prominent physician of Leesburg, died March 30, 1937, of pneumonia. He is survived by his widow, Mrs. Irene Stanton Wood.

Interment was in Lone Oak cemetery with members of the Masonic Orders, the Knights of Pythias and Woodmen of the World in attendance and participating in the services. The active pallbearers were young men who were particular friends of Dr. Wood: Nobel Brown of Webster, Ernest Wind of Dade City, Nash Le Gette of Lakeland, J. E. Shelfer, Jr., and Harvey Davis of Leesburg, and three nephews, Brandon, Lamar and Waldo Warren, all of Palatka. Honorary pallbearers were: Dr. H. C. Dozier and Dr. J. N. Moore of Ocala, Dr. George Dame of Inverness, Dr. C. S. Cherry of Center Hill, Judge J. C. B. Koonce, of Tavares, Dr. W. E. Mitchell of Bushnell, and Dr. H. K. Morrison, Dr. L. H. Oetjen, Dr. H. G. Holland, Geo. W. Chain, Dr. E. B. Fletcher, Dr. Chas. E. Rivers, Frank H. Lindeman and P. C. Gorman of Leesburg.

Dr. Samuel C. Wood was born December 26, 1876, in Lawrenceville, Georgia. After completing high school he entered the University of

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Georgia where he graduated with an A.B. degree, then secured his medical degree at the same institution. Here also he served his internship in the University Hospital.

Locating in Sumter County, Dr. Wood built up a good practice as a general practitioner but from the very first he took the greatest interest in obstetrics and the diseases of children. This interest grew as he developed and when he located in Leesburg in 1923 he had assisted in bringing into the world over 2,000 children, losing out of that great number only two mothers and three babies.

As the years passed the interest Dr. Wood felt in children grew. He took three postgraduate courses in child diseases in New York and spent three months with a company of American specialists in Europe attending child clinics under the best known specialists in European countries. He attended four baby clinics in Saluda, North Carolina.

Dr. Wood was active in fraternal and civic circles, being a member of Egypt Shrine Temple at Tampa, the Knights of Pythias and Woodmen of the World. He was a charter member of the Leesburg Kiwanis Club, the first service club formed in Lake County, and was the only charter member who had never taken a demit. He was surgeon for the Atlantic Coast Line Railroad and served as City Health Officer several times. He was a member of the American Medical Association, the Florida Medical Association and the Lake County Medical Society.

As an individual and through the underprivileged child committee of the Kiwanis Club, of which he was chairman for many years, he brought great joy into the hearts of many afflicted children. Despite his great interest in the medical attention of children, he grew in surgery and many children owe straight limbs and backs to the surgical skill he bestowed without thought of money reward.

Thousands of people in Lake and Sumter Counties have reason to mourn the death of this beloved man who apparently was in the prime of life when he was stricken and passed so suddenly. The public generally, accepting each day's work of the individual, awakens to his worth only when he no longer carries on his accustomed good work, but the death of Dr. Wood will be felt in that community for years to come.

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COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

The following papers constituted the scientific program of the meeting of the Dade County Medical Society held on the evening of the 7th at the Elks Club:

"Acute Hematogenous Osteomyelitis," Ferdinand A. Vogt, discussed by Don C. Eskew.

"Fractures of the Wrist," Arthur Weiland, discussed by Harrison Walker.

"Fractures of the Neck of the Femur," M. P. Travers, discussed by C. Burbacher.

The April meeting of the Society was held on the 2nd at the Elks Club. The scientific program consisted of a case report "Hypo-Proteinemia Causing Nonfunctioning Stoma Following Gastro-Enterostomy" by John McDonald; a fifteen-minute talk by A. J. Logie, Director of the Bureau of Tuberculosis, State Board of Health; and a talk by N. Sprout Heaney of Chicago on "Vaginal Hysterectomy" which was illustrated by lantern slides and moving pictures. A business meeting followed the scientific session.

DUVAL COUNTY MEDICAL SOCIETY

At the meeting of the Duval County Medical Society, held at the State Board of Health Building on the evening of May 4, the following symposium on "Respiratory Infections in Infants and Children" comprised the scientific program:

"Manifestations in the Nose, Throat, Ear and Sinuses."—W. E. Ross.

"Manifestations in the Chest."—J. W. Hayes.

"Manifestations in the Abdomen." — Luther Holloway.

"Manifestations in the Nervous System."—Thomas E. Buckman.

"Manifestations in the Urinary System." — Thomas M. Palmer.

LEE COUNTY MEDICAL SOCIETY

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★ *Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245*
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
N. Y. State Jour. Med., June 1935, Vol. 35, No. 11
Arch. Otolaryngology, Mar. 1936, Vol. 23, No. 3
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



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N. Y. State Jour. Med. 1935, 35—No. 11, 590; Laryngoscope 1935 XLV, 149-154. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245. Laryngoscope, 1937, XLVII, 58-60. ☐

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PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The regular meeting of the Pasco-Hernando-Citrus County Medical Society was held in Dade City with Dr. R. D. Sistrunk as host. Dinner was served at the Singing Kettle Restaurant and enjoyed by those present, who were Doctors Bradshaw, Creekmore, Jones, Harvard, Walters and Sistrunk.

After the dinner, the scientific meeting was held in Doctor Sistrunk's office. The minutes of the last meeting were read and adopted. A motion was made and carried that a letter be written from the Society to Dr. George A. Dame, State Senator, pledging its cooperation with him in any way and wishing him success as State Senator.

A report of the proceedings of the Florida Medical Association meeting in St. Petersburg was given by Doctors Creekmore, Harvard and Walters. Clinical cases were reported. Dr. S. C. Harvard of Brooksville invited the society to be his guests on May 13.

PINELLAS COUNTY MEDICAL SOCIETY

A Library Review, by which items of current general interest from medical literature, was the feature of the meeting of the Pinellas County Medical Society held April 16. Drs. A. S. Anderson, W. M. Davis, John A. Herring, A. L. Mills and W. C. McConnell prepared reviews for presentation at this meeting.

At the meeting of the Society held at the Shrine Club on May 7, Judge C. I. Carey and Dr. T. E. Morgan were the featured speakers. Judge Carey gave valuable information regarding the legal side of medicine, while Doctor Morgan reported on the Pinellas County Health Unit.

ST. JOHNS COUNTY MEDICAL SOCIETY

THE ST. JOHNS COUNTY MEDICAL SOCIETY HAS BECOME THE FOURTEENTH SOCIETY TO REPORT 100% OF 1937 DUES PAID. THIS SOCIETY, WHICH HAS A MEMBERSHIP OF ELEVEN, IS HEADED BY DR. CHARLES C. GRACE, PRESIDENT; DR. W. D. WEBB, VICE-PRESIDENT; DR. R. D. HARRIS, SECRETARY; AND DR. A. C. WALKUP, TREASURER. CONGRATULATIONS, ST. JOHNS COUNTY MEDICAL SOCIETY.

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A WORD OF GREETING TO ALL AUXILIARY MEMBERS

MY DEAR FRIENDS AND AUXILIARY CO-WORKERS:

As your leader for the coming fiscal year of the Woman's Auxiliary to the Florida Medical Association, I extend to you my sincere greetings and best wishes for a happy and profitable year. May I express to you my deep gratitude for the high honor you have conferred upon me in electing me your president. It is a very sacred responsibility, and I shall need your loyal support and whole-hearted cooperation in trying to make this one of the best years in the history of our Auxiliary. I hope that our association together will enrich our lives by bringing us into a closer fellowship, and helping us to feel that oneness in our aims and purposes for the great organization we have learned to love—an organization dear to the hearts of all of us, and one of which we have each become a vital part. May we aim high and work together for the common good of all.

I trust that each county president will see that her officers and chairmen are well supplied with the Hand Book, which can be secured by writing to Mrs. Lucius Cole, 1117 North Lathrop Ave., River Forest, Ill. By a study of these Hand Books every Auxiliary member will become an "informed member" and be more efficient in her work, as the duties of every officer and chairman are clearly defined. The price is forty cents a copy.

I want to urge you to read our Auxiliary page in the Journal regularly, and learn what other auxiliaries are doing. And don't forget to send to your state Press and Publicity Chairman, Mrs. A. K. Wilson, 4437 Herschell St., Jacksonville, regular news items of your own auxiliary meetings.



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We hope to have a Board meeting in Orlando some time in June. Each county president will be notified, and is requested to be present and ready to offer any helpful suggestions in regard to our work for the coming year.

I am asking each county auxiliary to please send to me and to each of your state officers and committee chairmen, a list of your new officers for 1937-1938. Your promptness in doing this will be greatly appreciated, as this information will enable each of us to get our work better organized and well under way in the beginning of the year.

I should like for each county auxiliary to change its fiscal year (if this has not already been done) to correspond with the state and national, so that all county auxiliary dues will be paid promptly each year by March 1, as the state books close March 15, and dues must be sent in to the state in time for the national dues to be paid by March 30, as this is their closing date. We like for our state to be in good standing, so please keep this in mind, as it is very important that all dues be paid promptly.

I am wishing for each and every one of you a pleasant summer and a happy vacation. If I can be of any service to you in any way at any time, please command me. I shall consider it a great privilege.

May we adopt as our slogan for the ensuing year the familiar words of Mason Knox:

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Protamine Zinc Insulin, Squibb, is marketed under license from the Insulin Committee, University of Toronto. It is supplied in 10 cc. vials ready for use. The preparation appears milky because the Insulin is in suspension. Each cubic centimeter, after it has been brought into uniform suspension, contains 40 units of Insulin together with protamine and 0.08 mg. of zinc. It is stable in the cold for not less than six months and should not be used after the expiration date stamped on its wrapper. Protamine Zinc Insulin should be administered only subcutaneously.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	T. A. Snow, M.D., 103 E. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	19	70%
Bay	D. M. Adams, M.D., Panama City	Allen H. Miller, M.D., Millville			10	83%
Brevard	W. C. Page, M.D., Cocoa	Bob Schlernitzauer, M.D., Rockledge	3rd Tuesday	Varies	4	40%
Broward	George S. McClellan, M.D., Pompano	Oliver C. Brown, M.D., 915 Sweet Bldg., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	28	100%
Columbia	T. H. Bates, M.D., Blanche Hotel Annex Lake City	M. W. Spearman, M. D. Morrison Bldg. Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	11	100%
Dade	R. N. Burch, M.D., 1774 S.W. Eighth St. Miami	Walter C. Jones, Jr., M.D., 802 Huntington Bldg. Miami	1st Friday 8:30 P.M.	Elks Club	213	81%
DeSoto-Hardee-Highlands	Gordon H. McSwain M.D., Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	19	100%
Duval	Kenneth A. Morris, M.D., 237 W. Duval St. Jacksonville	George W. Croft, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	128	81%
Escambia	J. C. McSween, M.D., Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	33	83%
Hillsborough	George L. Cook, M.D., 443 W. Lafayette Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	95	97%
Jackson	C. H. Ryals, M.D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	12	80%
Lake	LeRoy H. Oetjen, M.D., Leesburg	W. L. Asbton, M.D., Umatilla	1st Thursday 12:30 P.M.	Eustis	14	82%
Lee	H. Quillian Jones, M.D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M.D. 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	11	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	L. L. Dozier, M.D., Tallahassee	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	33	84%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			4	100%
Manatee	Lowrie W. Blake, M.D., Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	12	100%
Marion	Ralph E. Russell, M.D., Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	22	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	3	100%
Orange	F. H. Harms, M.D., 64 No. Court St. Orlando	Hewitt Johnston, M.D., Box 2002 Orlando	3rd Wednesday 8:30 P.M.	Varies	54	93%
Palm Beach	Bailey B. Sory, Jr., M.D., Brazilian Court Hotel Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	51	93%
Pasco-Hernando-Citrus	W. Wardlaw Jones, M.D., Dade City	G. R. Creekmore, M.D., Brooksville	2nd Thursday 7:00 P.M.	Varies	11	69%
Pinellas	N. M. Marr, M.D 812 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D. 1005 Equitable Bldg. St. Petersburg	1st and 3rd Friday 6:30 P.M.	Shrine Club St. Petersburg	84	97%
Polk	R. E. Gilbert, M.D., 19 Postal Arcade, Winter Haven	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb. April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	52	88%
Putnam	H. A. Johnson, M. D. Palatka	F. Emory Bell, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Johns	Charles C. Grace, M.D., East Coast Hospital St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	11	100%
St. Lucie-Okeechobee-Indian River-Martin	H. D. Clark, M.D., Ft. Pierce	Grover C. Hardie, M.D., Ft. Pierce	3rd Thursday 8:00 P.M.	Varies	14	100%
Sarasota	Arthur O. Morton, M.D., Commercial Court Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	10	59%
Seminole	H. D. Smith, M.D., Touchton Drug Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	13	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E Mitchell, M.D., Bushnell	2nd Tuesday	Varies	4	100%
Taylor	G. H. Warren, M.D., Perry	J. C. Ellis, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	7	100%
Volusia	J. Ralston Wells, M.D., Woolworth Bldg. Daytona Beach	R. L. Miller, M.D., 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	Varies	35	88%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood	R. B. Spires, M.D., Defuniak Springs	3rd Thursday 8:00 P M	Varies	5	100%

NOTE—Secretaries: Please submit information to complete the above schedule.

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The JOURNAL of the Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XXIII
NO. 12

Jacksonville, Florida, June, 1937

Yearly Subscription, $3.00
Single Copy, 30c

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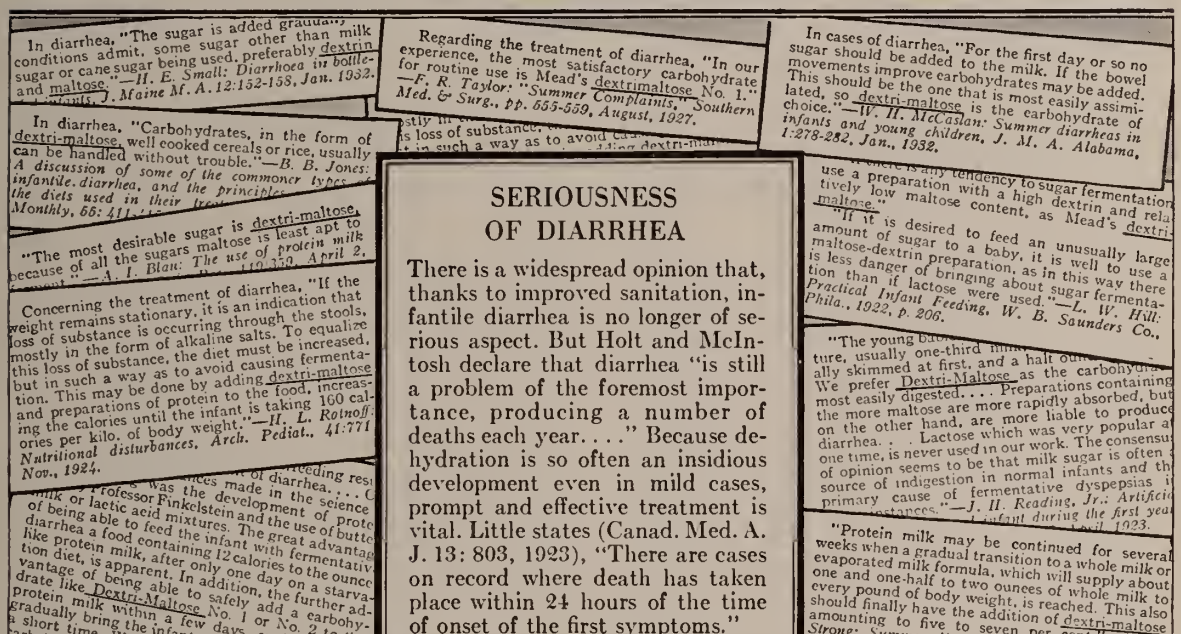
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VITAMIN REQUIREMENTS OF MAN

IV. VITAMIN B_1

● The multiple nature of vitamin B has been definitely established by intensive research within the past decade. Considerable quantitative information is now available concerning the requirements of certain species of animals for the various factors contained in the vitamin B complex. At the present time, however, the anti-neuritic vitamin B_1 is the only one of these factors for which the minimum requirement for man can be postulated.

Beriberi-preventing diets of Chinese coolies and natives of Java have been estimated to contain 200 International units of vitamin B_1 (1). Practical use is made of knowledge such as this in the Philippines, where the Bureau of Science, in a successful effort to combat beriberi, dispenses tikitiki (vitamin B_1 concentrate from rice polishings) containing approximately 200 International units of vitamin B_1 per daily dose.

It is generally agreed that the absolute requirement for this factor may be variable, depending upon such factors as size and caloric intake of the individual. However, equations have been derived which take into consideration some of these variables and are useful in estimating the adult vitamin B_1 requirement (2).

Application of these equations indicate that approximately 225 International units of vitamin B_1 per day are required for the average American adult. The average daily infant requirement has been estimated to be 50 International units, increasing to 200 units at the time of adolescence (1). The League of Nations Technical Commission recommends a daily intake of over 150 International units for pregnant and lactating women (3).

While it may be possible to estimate the daily intake of vitamin B_1 which will prevent clinical beriberi, it is not yet possible to state the minimum amount of the vitamin which, when imposed on an otherwise adequate diet, will promote optimum nutrition. There is increasing belief that some of the vague disorders, noted clinically, may be in reality manifestations of suboptimal vitamin B_1 intake (4).

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(1) 1934-35. Am. Pub. Health Assn. Year Book. Page 70

(2) The Vitamin B Requirements of Man. G. R. Cowgill Yale University Press. New Haven. 1935

(3) 1936. Nutr. Abst. and Rev. 5, 855

(4) a. 1936. J. Am. Med. Assn. 106, 261
b. 1935. Ibid. 105, 1580

(5) a. 1932. Ind. Eng. Chem. 24, 457
b. 1932. J. Nutrition 5, 307
c. 1934. Ibid. 8, 449
d. 1935. Ibid. 11, 383

(6) 1934. U.S. Pub. Health Rpts. 49, 754

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XXIII | Jacksonville, Florida, June, 1937 | Number 12

THE VALUE OF SKELETAL TRACTION, ESPECIALLY IN SOME FRACTURES NEAR THE JOINTS*

PRESCOTT LEBRETON, M.D.,
St. Petersburg.

The last few years have made many of us more familiar with the use of hardware in treating fractures. Tongs went into discard some time ago. Plates with screws we still find indispensable for certain types but they mean open operation, with its possibilities. It is the increasing popularity of Steinman pins and steel wires which has changed our viewpoint, where traction, fixed or movable, is indicated. Also we have learned to depend with considerable confidence on the resistance to infection which Nature displays when metal is introduced into our anatomy and is left in situ for many weeks, extending from outside the skin to the interior of a bone. As one grows more accustomed to using skeletal pulls, he learns to value the direct and forceful traction, so much more efficient than the pull of adhesive. Consequently, as he views the first film of a difficult fracture case, a variety of solutions of the immediate problem comes into his mind in the effort to avoid direct open operation on the fracture. Previous experiences with skeletal traction suggest this or that combination, so that the case can be controlled by simple means. We can often anticipate a satisfactory check-up film when we have used pins or wire, reduced the fracture, and applied a dressing which surely holds a good position of the parts.

The automobile continues to furnish us with bad fractures, often with unusual and bizarre features. The old-fashioned ready-made metal splints, which gave fixation only, are of no value in these cases. Badly comminuted fractures near the joints are not easy to handle when a good end result is sought. Especially is this true when there is comminution close to the joint, or where the fracture is compound, or where there are fractures above and below a joint, necessitating pulls in more than one direction. Plaster casts incorporating the metal for fixed traction, or with windows for movable traction, are, of course, essential. The surgeon who treats fractures has to have today quite extensive equipment, and needs many strings to his bow. Besides the wire and pins with their accessories are the Hoke traction apparatus, the Roger Anderson or similar apparatus, the redresseur for lateral compression, and the newer forcible correction machines for the leg or forearm. These are of value and their exact place in treatment will be determined in time.

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the S.S. "Florida", April 27, 28 and 29, 1936.

Case 1—Fracture Dislocation of Ankle.



(A) Before Reduction. (B) After Reduction. (C) Before Reduction. (D) After Reduction.

In calling attention to certain types of fractures near the joints, the writer has reviewed his cases of the last three years and selected seven to illustrate different types of treatment. Six were adults. Five were automobile cases. The injuries were fractures near the ankle, knee, hip, elbow and shoulder. In two cases the traction was by weight and pulley, the countertraction being the weight of the body. In one case, a Roger Anderson splint was used, the countertraction being the well leg. In one case, a Hoke traction was selected, the countertraction being the side of the chest. The other cases had traction and countertraction by skeletal pull. A brief summary follows:

1. Woman, aged 35. On December 22, 1935, while in an automobile, her left ankle was badly fractured from an accident. There were two lacerated wounds, one on the top of the foot and one over the front of the ankle where the tendons were exposed and the fracture was compound. The roentgenogram showed the dislocated astragalus, the comminution above the ankle, and the club foot deformity, the forefoot being at a right angle to the rest of the foot. After cleansing and trimming, pins were run through the heel and upper tibia; by manipulation under the fluoroscope, the forefoot and the astragalus were reduced and traction was maintained by manual pulls on the pins until plaster was applied. On Jan. 25, 1935, the pins were removed; the wounds were cleaned and dressed through windows. On Feb. 8, the cast was removed, and union was evident with a good position of the foot. There was no lateral motion of the foot at that time, and limited ankle motion. A recent examination showed that she walks well, with fair ankle motion and one-third lateral motion of the foot. She is active again at her housework.

2. Man, aged 38. On Jan. 2, 1935, while standing back of his automobile his left leg was struck by the bumper of an automobile, causing a bumper fracture. There was a bad gash in the calf on the inner side and the sliding fracture of the tibia close to the knee joint was almost compound. As in the last case, after cleansing, two pins were placed in the tibia, the upper above the fracture. With the aid of the fluoroscope, a cast was applied holding the pins and leg in position. On Feb. 2, the pins were removed, and the wound was nearly healed. On Feb. 13, the old cast was removed; the union was still imperfect, as these fractures heal slowly but position was excellent. A thin cast was applied, and he returned North. No word was received later, but he should have had a perfect result.



Case 2 Bumper Fracture Below Knee—(A) Before Reduction.



(B) After Reduction.

3. Dentist, aged 42. On February 15, 1935, in a collision, he was thrown forward, striking his right tibia against a radio box. There was a comminuted fracture of the bone, fissures running transversely and up into the joint, with a large fragment projecting forward above the main shaft. There was a dislocation backward of the upper part of the tibia. The fibula was not broken. Deformity was marked. An open operation was done that day, and while traction was exerted, the large fragment was fastened to



Case 3 Fracture Below Knee—(A) Before Reduction.



(B) After Reduction.

the shaft by kangaroo through drill holes. A plaster cast was applied in fifteen degrees flexion, to relax the gastrocnemius. On Feb. 8, as the lateral x-ray showed a cleft opening into the knee joint, a window was cut above the heel and a pin inserted through the os calcis. Traction was applied to the pin with the cast on a Braun splint. On Feb. 13, the x-ray was satisfactory for position and as a nasal deviation showed up from a fracture of the nose, force was used to straighten the nose. In due time the traction was removed, and he was up on crutches. On March 10, the cast was removed, and a slight sway back was evident just below the knee, with ten degrees limitations of full extension. One year later he was walking with full function.

4. Young man, aged 17. On March 31, 1933, he was knocked down by a horse and received a fracture above the right knee, following the epiphyseal line except for a short distance on the inner side where the fracture line ran up into the shaft. The deformity was marked. A Roger Anderson splint was applied, and force used to correct the deformity as traction was made. The next day the x-ray showed a very perfect reduction. On April 26, the apparatus was removed and a light cast applied. On June 14, function was good, but flexion still somewhat limited. In the early fall, function was perfect, and there was no disturbance in growth of the leg.

5. Baby, three days old, weight five pounds. At birth, the left femur had been broken a short distance below the hip, overriding with the upper fragment flexed. When first seen, on Nov. 29, 1935, a back splint was made of wire to fit the tiny leg and overhead traction was used under the flexed knee. As the skin began to ulcerate very soon under the calf, the thigh was bandaged to the body, but the x-ray showed bad distortion. Therefore, on Dec. 10, a wire was driven through the lower femur and overhead traction used with the knee at a right angle. As the proximal fragment still was flexed, the line of traction was changed to a sixty degree angle, and the alignment was perfect. The weight used was one and a half pounds. On Dec. 29, the wire was removed and union was firm. On Jan. 16, 1936, the leg was in excellent condition, with good power and normal length. A slight drop foot from the pressure of the wire splint had disappeared. This case is most interesting as the books on fractures do not mention treatment in this way but argue that deformity and shortening resulting from the old methods are overcome during growth.

6. Man, aged 42. On May 19, 1935, he had a partial crush of the left arm under a truck which overturned. Examination showed a lacerated and swollen arm with a puncture of the skin from a compound fracture below the elbow, with inability to extend the fingers and wrist. X-rays showed a complete inward dislocation of the elbow, fracture of the head of the radius and two fractures of the ulna. An open operation was performed, incision over the radius. A large quantity of black blood was



Case 4 Fracture Above Knee—(A) Before Reduction.



(B) After Reduction.

removed to lessen the distention; the head of the radius was removed; the muscles attached to the outer condyle of the humerus were found torn to pieces, with no trace of the musculospiral nerve. The dislocation was reduced, chromic sutures used to bring the capsule together and hold the bones in place. Then a pin was run through the olecranon and another through the forearm just above the wrist. With the arm in a traction apparatus, gentle force was used to get the ulna in alignment, and a cast was applied from palm to axilla, incorporating the pins. Two days later, the x-rays were satisfactory, and the drop wrist was evident. On June 17, the cast was removed, and the wound had healed. Small ulcers from the abrasion at the wrist remained. The fracture had healed, but the elbow joint was loose and painful. On July 5, a marked atrophy had replaced the swelling and the joints were painful under physiotherapy. On Oct. 14, tendon transplantation was done at the wrist; the flexor carpi radialis was buttonholed into the long flexor at the thumb, and the flexor carpi ulnaris was transferred to the ex-



Case 5 Fracture Below Hip—(A) Before Reduction



(B) After Reduction.



Case 6 Fracture Dislocation of Elbow—(A) Before Reduction.



(B) After Reduction.

tensor ulnaris. On November 4, the cast and the sutures were removed. On Nov. 25, fair function had returned, as the wrist did not drop and pinch power had returned to the thumb. All motions at shoulder, elbow and wrist were limited one-third to one-half but the man was well satisfied at having his arm partially restored instead of being amputated.

7. Young man, aged 19. On Jan. 5, 1935, in an automobile collision, he had as his main injury a simple fracture of the left humerus below the shoulder, with a loose triangular chunk at one side. The next day, a pin was run through the olecranon and a shoulder spica and Hoke traction applied. Check-up x-rays were satisfactory. On Feb. 2, the pin and the traction were removed. On Feb. 20, the cast was removed and he later was discharged with an excellent result.

DISCUSSION

Dr. W. C. Payne, Pensacola:

To lessen the enormous economic loss and the



Case 7 Fracture Below Shoulder—(A) Before Reduction.



(B) After Reduction.

severe and prolonged suffering caused by fractures is a problem facing our profession. This has always been true but accidents caused by automobiles and modern machinery have increased to an alarming extent the numbers injured and the severity of fractures in the last few years. We may well take pride in the work done by orthopedic surgeons in improving our methods of handling fractures. A great proportion, however, of the physicians who are called upon to treat fractures are not orthopedic surgeons and obtained their training before skeletal traction was advocated. The problem now is to get the knowledge of the advantages of the proper use of this method to the men doing fracture work. There are a great many fractures, of course, which can be successfully treated by the splint and fixation method. There are a great many fractures, however, which can be successfully treated only by skeletal traction. I think Dr. LeBreton is doing real service in stressing the importance of skeletal traction in selected cases. It is my opinion that too many men treating fractures have an exaggerated idea of the technical difficulties in applying the apparatus required in skeletal traction. It is true that a certain amount of such apparatus is necessary. It is not difficult, however, to apply this apparatus. The most technical part of the application is insertion of either the Steinman pin or the Kirschner wires. Either of these can be inserted under local anesthesia with surprising ease and without discomfort to the patient, and traction can be maintained for an indefinite period without discomfort. The advantage of skeletal traction in certain fractures is so obvious that one finds it difficult to argue about it. It is of paramount importance to our profession to improve our methods of treating fractures. And it is discouraging to observe how many men doing fracture work have not yet begun using skeletal traction.

In conclusion, I wish to congratulate Doctor LeBreton on his excellent paper.

SOME OBSERVATIONS ON BLOOD PRESSURE*

J. G. Gainey, M.D.
Blountstown.

Blood pressure may be defined as the force exerted by the heart. This force is measured in millimeters of mercury and recorded as, (1) maximal or systolic; (2) minimal or diastolic; and (3) pulse pressure, or the difference between the two.

Normal blood pressure is merely an assumption of the average pressure reading for age and sex in healthy people only. Any person visiting a doctor's office for personal professional consultation is a potential clinical patient, and cannot be regarded as a normal, healthy person regardless of the negative physical findings. The average blood pressure reading from such a group could not be expected to fall within a so-called normal limit. In taking these pressures, more care should be exercised than I believe most of us are in the habit of using, as there are so many points of detail that will produce errors in a correct reading if not properly carried out. For instance, a hasty release of the air pressure against the column of mercury will give approximately three sound phases, and, in some, only two, where the pressure is very high. Some authors (Tice) give as many as five sound phases quite distinct in a correct blood pressure reading covering not more than from four to ten points on the mercury scale.

When used intelligently, the sphygmomanometer has a distinct value in physical examination and gives information which cannot be obtained in any other way. Otherwise, it can be a dangerous instrument so far as management and relation of physician to patient is concerned. Too much importance has been forced upon blood pressure estimations and, in many cases, far out of proportion to their value. Whatever instrument may be used for taking blood pressure, there is none that is absolutely correct.

To the laity, high blood pressure is rarely associated with anything but a "bad heart". We are taught that a diastolic pressure of 100 or more should be called one of high pressure regardless of the systolic pressure. However, the laity interprets high blood pressure only by the numerical value of the systolic pressure and rarely are they concerned by either the diastolic or pulse pressure. If their systolic pressure be 140 with a diastolic pressure of 110 or more, they are much less concerned than if their systolic be 160 with a diastolic of 100 or lower.

With so much variation we see in blood pressure from time to time, what then should we term a high, low, or a normal pressure, and when should we tell a patient the condition of

*Read before the Sixty-fourth Annual Meeting of the Florida Medical Association, held in St. Petersburg, April 5, 6 and 7, 1937.

his blood pressure, and should he be so informed on his first visit to our office? Many patients visiting the doctor for the first time do so at the advice of some relative or friend. These patients come to have their blood pressure taken, and at that time are living under an environment of temporary fear and nervous tension lest their blood pressure really will be found to be high, and that consequently their remaining days are numbered and are sure to be spent in misery and suffering. Under such conditions their pressure will register 10 to 20 points higher than usual, or maybe more. After the reading is made and we find such a condition to exist, we then inform them that their pressure is a few points higher than it should normally be. We usually then conclude by writing out a few favorite prescriptions, advising them about their diet and daily habit, and send them away to return in ten to fourteen days. (We must admit that these patients will follow instructions for a while with the greatest care.) On the second visit to the office they come with much less fear and feel more at ease. We take their pressure again and find, in many cases, that it has dropped several points, maybe 10 or 20, and we advise them so. They are delighted. What then is the answer? Did we make a hit with our medicine and advice, or was the response due to relief from fright, or was it due to the fact that the patient really had been taking better care of himself?

Many such conditions as the above led the writer to compile some statistics from his personal records to compare with some text findings. These statistics which follow comprise a series of 452 cases of readings taken both at the office and bedside.

Age	No. Cases	Av. Sys. P.	Av. Dias. P.	Av. P. P.
Under 20	25	118	76	44
20-30	133	124	78	44
30-40	111	126	78	46
40-50	85	136	86	50
50-60	56	158	96	60
60-70	35	166	98	68
Above 70	7	202	106	96

We note from the above table that the average readings vary very little up to 40 years. However, there is a gradual increase in each reading of each decade. But this is not so noticeable until we pass the age of 40. Then we note that after 40, or during the last half of a contemplated life span, the systolic, diastolic, and pulse pressure each rise much higher in proportion than during the first half.

The old rule of a person's blood pressure, systolic, being equivalent to his age plus 100 is approximately true in this series only after the age of 40. The average systolic pressure of this age is 153. The average age is 55. The average pulse pressure of this series after the age of 40 runs fairly true in comparison to the actual figure representing the average. The average is 55, the average pulse pressure 56.

After the foregoing table, which comprises both male and female, I wish to differentiate between the two sexes in relation to hypertension, hypotension, and a total of those having a high diastolic reading.

Class	Males	Females	Total	Percent
Hypertension	26	61	87	19.2
Hypotension	19	19	38	8.5
High diastolic	..	..		6.5

We note from the above table that the hypertension cases were 19.2% of the total. This is an increase of more than 100% over the hypotension cases. Six and one-half per cent patients with a reasonably normal systolic pressure had a high diastolic pressure. Now the question may arise: should this 6.5% of high diastolic cases be added to the 19.2% of cases having high diastolic and systolic, and classify both as hypertension cases? This would give a total of 25.7% hypertensive cases.

In reviewing this series of cases, the chief points of interest to the writer lay in the fact that he was able to observe each case from a clinical standpoint, recording the objective and subjective symptoms, then attempting to interpret the relations of the symptoms to the existing blood pressure. There has been no attempt made in this series to outline all of the underlying pathological conditions associated with the individual blood pressure readings. However, many observations run quite in accord with text book findings.

Some questions and points of interest from the above series may be noted as follows:

1. Seventy-six per cent of the hypertension cases gave a history of constipation and indigestion.
2. Eighty-three per cent of cases gave a history of bad teeth and gums that were neglected for a long period of time.
3. One hundred per cent of the hypertension cases gave a history of either constipation, indigestion, bad teeth, or kidney trouble.
4. In the cases designated as hypertensive, 70% were female. If this be true, can exposure, hard labor, chronic tobacco, and alcoholism be considered as predisposing factors in causing high blood pressure?
5. Maimness and death are more prevalent from paralytic strokes in the males.
6. Is hypertension following hysterectomy due to the usual increase in body weight, or to the loss of an internal gland hormone?

7. Hypertension in children is almost always due to an interstitial nephritis, and is usually associated with a hemorrhagic condition.
8. Low blood pressure is more often associated with the early conditions of wasting diseases, as the anemias, malaria, and intestinal parasites.
9. A high diastolic pressure is about equal in men and women. It is more prevalent at the ages of 20-40 and usually associated with some emotional disturbance.
10. A fluctuating high pressure is more significant than a constant high pressure.
11. So long as there is a notably high systolic and diastolic with a constant pulse pressure, there is less likely to be the common dizzy and fainty feeling. A drop in the systolic pressure with no variation in the diastolic pressure usually indicates a fast failing heart.
12. A fluctuating blood pressure in the absence of an arteriosclerosis is usually a symptomatic condition; but a constant high pressure with an associated arteriosclerosis may be classed as a chronic diseased condition.
13. The true hypotensive cases offer very little resistance to diseases. (Tice.)

In conclusion I wish to tabulate some very familiar questions that our high blood pressure patients ask from day to day:

1. Is high blood pressure an inherited condition?
2. How high will my pressure have to go to cause a stroke?
3. If my pressure continues very high, am I likely to have a stroke if I take good care of myself?
4. Do headache and shortness of breath always mean high blood pressure?
5. Is low blood pressure also dangerous?

Answers to the above questions are usually based upon the physician's observation and experience. A summary of detailed histories and records will often reveal many points of interest hitherto misunderstood.

DISCUSSION

Dr. T. M. Rivers, Kissimmee:

It doesn't seem just right to let a good paper go by and have nothing to say. I want to mention something that I have noted in observing a great many cases of blood pressure. My observation is that a person whose tendencies are hypertensive may have a rise in systolic blood pressure rather early and gradually until it may go up a little above 200 but may at the same time develop a heart muscle that will withstand this so that the heart will not fail.

The same thing may happen to the arterial system and it may be that the arterial system will withstand the high tension, but if we have a patient whose blood pressure has been running low; that is, low on a tracing of a series of years and finally, for some reason, that blood pressure rises rapidly, that is the person who gets the results from the weak arteries and we get our apoplexy as a result—from the sudden rising where the arterial system has not built up to withstand the pressure, or if it does withstand this, we get the bad results from the other end of the line; that is, the failure of the heart—the heart being too weak to withstand the pressure causes a sudden dilatation or failure of the heart.

Dr. J. H. McCurdy, Springfield, Mass.:

I have been making a study recently of some 1,600 subjects and comparing them with Donald Bank's of the Royal Air Force of England. There are one or two points I would like to raise. I will just speak of the diastolic pressure. Dr. Banks takes the position that diastolic pressure between 75 and 90 are the normal ranges which the Royal Air Force will accept. They deduct proportionately, if they have higher or lower diastolic counts.

I have written to Dr. Banks with reference to his basis. I find that I have scores in lower ranges. The higher range, 90, applies very well but I find a good proportion of the men in all of these ranges running below Bank's 75. Why, I don't know but those are the facts. I am trying to get the figures now from the American Air Force and see how they compare as to diastolic, systolic and pulse pressure.

Dr. Z. Brantley, Grandin:

I wish to speak only a moment to ask the doctor a question: In taking pressure for a long time, I have been taking in both arms if I am not in too big a hurry and I find very seldom that the two arms register the same pressure. For instance, I had one case in which the systolic pressure was 35 points higher in one arm than the other. However, the proportion of the diastolic and systolic was the same. I just wish to ask, in cases where there is quite a variation in pressure, how would you determine what the real pressure is? The pressure taken by different doctors and getting different results is probably due to the fact that it was taken in a different arm by the different doctors.

Dr. J. G. Gainey, Blountstown (concluding):

I wish to thank these gentlemen for their kind discussions.

I am not familiar with the diastolic pressure range of 75 to 90, given as a standard of acceptance by the British Air Corps, but I would presume these figures are given as a reasonably safe pressure range for a certain age limit such as is given by the many insurance companies of America. I do not believe that such a diastolic

pressure range would hold true especially here in the South.

In reply to Dr. Brantley's question, there are many things to be considered as etiological factors for producing a wide variation of pressure readings in different arms of the same patient. Where the variation of the two arms is small, I consider the mean reading as the proper one at that particular time. However, where there is a consistently wide variation, I usually think of a cardiac disturbance or an intracranial lesion. I recall two cases I have had recently in which the outstanding symptom was a partial hemiplegia. Both patients were comparatively young adults and instead of finding the expected hypertension present, both were hypotensive. In each case, both arms gave a fairly constant systolic pressure but a marked variation in diastolic. No heart lesion could be found. These cases were diagnosed by a neurologist as intracranial vascular lesions.

BRAIN SURGERY AND EPILEPSY*

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Usually we think of epilepsy as a hopelessly incurable disease with an obscure etiology, leading to physical weakness and mental deterioration. In many cases of idiopathic epilepsy the pathology is unknown and in spite of careful treatment the progress is down hill. Many are benefited and some cured when adequate treatment is started in the early stages. Most cases of epilepsy, whether generalized or focal in character, especially when the attacks occur after adult life, should have a thorough neurological examination and frequently encephalographic studies to determine the probable lesion responsible for the trouble.

Epilepsy is not a distinct disease, as many pathological lesions have been found which may produce the convulsive state. It is a symptom of some underlying brain disease and the term should be used only in those cases where the pathology cannot be demonstrated and when the attacks have recurred at definite intervals.

It is impossible to name all the diseases of the brain which may be associated with convulsions but some of them are brain tumor, abscess, trauma, meningo-encephalitis, cerebral vascular disease, syphilis, localized scars and adhesions between the brain, meninges and skull. A thorough search by encephalographic studies will frequently disclose some definite pathology in the brain. With more complete examinations and the demonstration of underlying pathology, the diagnosis of idiopathic epilepsy is less often made.

Probably every case of so-called epilepsy has some basic change in the structure or physiology of the brain which renders it more susceptible to the action of exogenous or endogenous toxins. It may be difficult to say whether this is developmental, or the result of a brain injury and hemorrhage from birth, or a mild meningo-encephalitis associated with an infectious disease in childhood.

Foerester and Penfield[1] have explored the cerebral cortex by electrical stimulation looking for epileptogenic zones. In some cases they found dense scars extending from the surface into the brain as far as the ventricular wall. These scars are freely vascularized and contain bands of fibrous and glia tissue, which may contract and pull out the underlying ventricle and cause a shifting of the ventricular system to the same side. Electrical stimulation of the brain cortex about these scars may throw the patient into a convulsion.

It has been shown by Cobb and Finesinger,[2] Chorobski and Penfield,[3] and others that the cerebral and meningeal vessels have a nerve mechanism capable of producing a vascular spasm. Penfield[4] has found during operation under local anesthesia at the beginning of a convulsion, local areas of vasoconstriction and cortical anemia. These localized areas are called epileptogenic zones and stimulation of them may cause a typical convulsion. If this irritable zone or scar is found, its excision will be a logical procedure and may effect a cure.

Penfield[5] has shown that severely injured brain tissue heals by forming a thick scar of fibrous and glia tissue supplied by an abundant network of blood vessels. He has shown also that a clean incision of brain heals with only a little glia tissue and without a vascularized fibrous tissue scar. This being true, the clean excision of a thick vascularized scar in the brain may be followed by a healed surface of smooth glia tissue bathed by cerebrospinal fluid.

Jacksonian attacks and focal manifestations of generalized convulsions are indicative of a local

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the S.S. "Florida", April 27, 28 and 29, 1936.

lesion in the brain. Foerester and Penfield have mapped out the cerebral cortex by electrical stimulation somewhat similar to cortical localization on monkeys made by previous workers. They found that stimulation of the frontal adversive field caused an attack without aura manifested by turning of the eyes and head to the opposite side, followed by a spasm of the extremities on the same side, and sometimes by a generalized convulsion. With the lesion posterior to the motor area the attacks were often associated with an aura, corresponding in character to the function of the brain involved. In the occipital cortex the attack may be preceded by flashes of light in the opposite visual field. In the occipito-temporal region there may be hallucinations of vision with turning of the eyes, head and body to the opposite side. In the temporal lobe there may be hallucinations of hearing with the lesion in the superior temporal convolution, or hallucinations of smell and taste with involvement of the uncinate gyrus. A lesion in the motor area may produce a true march of symptoms seen in a typical Jacksonian convulsion. For example, the attack may start in the thumb and spread to the hand and arm and then involve the face and leg on the same side. The patient usually retains consciousness unless the convulsion passes to the opposite side when it becomes generalized with loss of consciousness.

Every case of Jacksonian convulsion should cause one to consider the possibility of a brain tumor, abscess, or other focal lesion of the brain. Dowman and Smith[6] found convulsions in 19% of brain tumors. Sachs and Furlow[7], in a series of 724 cases of brain tumor, found the incidence of convulsions to be 20.7%. They found cerebral tumors produced convulsions in 34.8% and cerebellar tumors in 4.8%. Of the pathological types the astrocytoma produced convulsions in 60%, meningiomas in 35.4%, and spongioblastomas in 38%. Parker[8] in a series of 313 cases of brain tumor found 31.6% were associated with convulsions. With the lesion in the frontal region convulsions occurred in 52% and in the temporal lobe the incidence was 31.8%. The closer the tumor was to the motor area the greater was the frequency of convulsions. It was also brought out that the character of the convulsion in brain tumor is not different from that in epilepsy.

Epilepsy due to trauma, likewise, may be focal or generalized in character. It is impossible to determine when convulsions will occur after the patient has received a skull or brain injury. There are certain locations and types of injury, as a depressed fracture with contusion and laceration of the brain in the parietal and frontal regions, which seem to render the patient more liable to epilepsy. The superficial cortical injuries are more liable to develop convulsions later in life than when the lesion is deeply seated in the brain substance.

The incidence of epilepsy in gunshot wounds of the head as given by Symonds[9] is from twelve to fifteen per cent. In the closed injuries as seen in civilian practice the incidence of epilepsy is much less. Glaser and Shafer[10] found the incidence of epilepsy in the more severe head injuries associated with demonstrable fractures and prolonged unconsciousness to be in the neighborhood of 2½%.

The most likely time for epilepsy to develop is anywhere from a few months to several years after the injury. The lesion may be an old depressed fracture of the skull, a localized cyst, or a scar on the surface of the brain. In time these focal lesions may set up a zone of cortical hyperirritability which may be responsible for the convulsion.

The treatment of epilepsy, no matter what the cause, is one of the big problems for consideration. It is always advisable to make a thorough search for localized pathology by a neurological examination and by encephalographic or ventriculographic studies of the brain. If the cause is due to a brain tumor, abscess, cyst, blood clot, localized adhesions or other focal lesion, the treatment should be primarily surgical. In many cases of Jacksonian epilepsy and where the attacks have focal manifestations indicating a localized lesion, an exploratory operation may be done for the purpose of finding the epileptogenic area by electrical stimulation and removing it.

In conjunction with the surgical treatment it will not be amiss to say something about medical therapy. The medical treatment of preventing convulsions is the same in all cases, regardless of the cause. The drugs used in controlling them are the sedatives as the bromides and the barbital products, usually phenobarbital.

In addition, a dietary regime may be outlined. It is often helpful to limit the proteins and carbohydrates and increase the fats as used in the ketogenic diet. Because of its disagreeable nature it may be difficult to get a patient to stick

to this diet to the extent of producing a state of acidosis. It has been shown that a state of hydration or too much water in the tissues of an epileptic patient will often induce a convulsive attack. By limiting the fluid intake and putting the patient on a dehydration diet, these seizures may be lessened or prevented. The foods allowed are the ones containing the least amount of water. It is best that the patient have encephalographic studies made by draining all the cerebrospinal fluid and replacing it by air to outline the brain and fluid spaces on x-ray examination for diagnosis before the treatment is instituted. This complete drainage of the cerebrospinal fluid spaces prepares the patient for the institution of the dehydration therapy and renders the latter more effective.

A few cases are reported representing surgical lesions associated with epileptic convulsions:

Case 1.—A. R., white, male, age 21. Admitted to St. Vincent's Hospital January 16, 1935, referred by Dr. R. R. Sullivan of Lakeland, Fla. For eighteen months patient had had petit mal attacks with numbness in right hand and right side of the body. For one month he had had six generalized convulsions, worse on the right side with biting of the tongue.

Neurological examination was negative except for slight inequality of the pupils, the right being larger; impairment of memory; little weakness of the right hand; diminished abdominal reflex on the right side and a bilateral Babinski sign.

Encephalograms showed the left ventricle failed to fill, and the ventricular system was shifted to the right.

At operation a cystic glioma classified as an astrocytoma was found and removed from the left temporal lobe. The patient has remained well and has been at work now for a year. During the first six months after the operation he had two slight convulsive attacks, but none in the last six months.

Case 2.—R. S., white, female, age 16. Admitted to St. Vincent's Hospital December 16, 1935, referred by Dr. J. C. Metts of Savannah, Ga. For six years the patient had had convulsions diagnosed as hysteria by several physicians. She had had frequent fainting and unconscious attacks and, since 1930, convulsions starting in the left arm. Numbness and weakness started in the left side one year previously and at the time of admission she could not walk or use the left arm. For the past several months she had had headache, dizziness, failing vision and vomiting.

Neurological examination showed almost complete left spastic hemiplegia. Eye grounds showed bilateral high-grade choked discs with visual impairment and optic atrophy. The tendon jerks were hyperactive with a Babinski and ankle clonus on the left. The abdominals were absent on the left.

X-ray of the skull by Dr. W. McL. Shaw showed multiple areas of calcification in the right parietal and frontal regions of the brain extending from the surface to near the midline.

At operation there was found a cystic glioma, an astrocytoma, involving the cortex of the frontal and parietal regions. The solid portion of the growth was located in the frontal region and was completely excised.

The patient made a good recovery and a recent communication from her mother stated that the paralysis of the left side had cleared up almost completely and she was walking with only a little limp of the left leg. She has some impairment of vision resulting from the optic atrophy. She has had no convulsions since the operation.

Case 3.—J. B., white, male, age 20, referred by Dr. C. C. Collins of Jacksonville. Admitted to St. Vincent's Hospital January 7, 1936, complaining of convulsions. In May, 1929, he received a depressed fracture of the skull in the right frontal region associated with unconsciousness for several days. He was operated on in another city and fragments of bone removed.

Five weeks previous to admission he had the first unconscious spell without warning, followed apparently by a generalized convulsion. Since then he had been taking phenobarbital but had had nine attacks with four in one day. The attacks started off by turning of the eyes and head to the left and spasm of the left arm.

Examination of the head showed a depressed scar in the upper right frontal region. The neurological examination was otherwise normal.

X-ray examination of the skull by Dr. H. B. McEuen showed a cranial defect in the right frontal region, roughly 1x1½ inches in diameter.

An osteoplastic flap was made surrounding the cranial defect and there was found dense adhesions and scar involving the brain, dura and the skull about the opening. A wide excision of the scar to the ventricular wall was done, making a plastic closure of the dura and repairing the cranial defect with a celluloid plate. The patient made an excellent recovery and at the present

time is in good health with no recurrence of the convulsions.

Case 4.—J. E. P., white, male, age 36. Admitted to St. Luke's Hospital April 1, 1935, referred by Dr. J. H. Pound of Chattahoochee. The patient was injured in an automobile accident on May 22, 1934, receiving a compound depressed fracture of the skull in the left frontal region. He was operated on five hours later but the wound became infected and had drained off and on ever since. He developed motor weakness and convulsions on the right side, and was operated on several times without improvement. For three months he had had headache, difficulty in talking, and a personality change, which caused his family to seek his admission to the State Hospital.

Examination showed in the left frontal region a herniating mass 1½ inches at its base partly covered by skin which was a brain fungus. There was a low grade choked disc, weakness of the right face, arm and leg, motor aphasia, and a very irritable and incooperative personality.

X-ray examination of the skull by Dr. T. H. Lipscomb showed a cranial defect in the left frontal region 3x4 cm. with an erosion in the posterior margin suggesting osteomyelitis.

Diagnosis of left frontal lobe abscess with brain fungus and osteomyelitis was made.

At operation the protruding area of brain fungus was excised and the fibrotic suppurating mass of brain tissue beneath was removed with the electrosurgical loop. At a depth of 4 cm. a large abscess cavity was encountered containing four to five ounces of pus. The abscess cavity was evacuated and irrigated. A soft rubber catheter was inserted for drainage and the cavity packed loosely with iodoform gauze. The wound gradually healed and on his discharge from the hospital five weeks later there was little superficial discharge, and the neurological findings had cleared up. He has remained well and free of convulsions except on two occasions, one in July and another in October when he omitted taking phenobarbital.

Case 5.—J. G., white, male, age five years. Admitted to St. Luke's Hospital November 19, 1934, referred by Dr. L. M. Rozier, West Palm Beach, Fla. The patient was a first baby with prolonged labor, but with no signs of brain injury at birth. At sixteen months of age he developed an intestinal upset associated with a high fever and convulsions on the right side, lasting twelve hours. Following this he was paralyzed on the right side for one month. He was slow talking and had never developed a normal speech. Five months previously the convulsions started again with the head and eyes drawing to the right, and spasm of the right arm and leg.

Neurological examination showed a weakness of the right arm and leg, indistinct speech, increased biceps and Achilles jerks on the right with a Babinski on the same side.

Encephalograms suggested the presence of adhesions over the cerebral cortex. At operation a subdural cystic membrane was found covering most of the cortex in the left parietal region. It was probably the result of an old subdural hemorrhage. The membrane peeled easily from the brain and no other pathology was found except some thickening of the pia arachnoid.

The first night after the operation he had several convulsions, probably due to a large ingestion of water at that time, but since then there have been no further attacks and he has made a good recovery. A recent communication from his mother stated he has remained in excellent health, is making good progress in school and remains free of convulsions.

These five cases represent some of the lesions of the brain associated with epileptic convulsions and benefited by an operative procedure directed at the removal of the underlying pathology. Some of the cases are too recent to say that a cure has been effected but it is reasonable to expect that the improvement will continue, since the lesion responsible for the cortical irritation has been removed. It is probable that the tendency for convulsions will disappear after the hyperirritability of the brain gradually subsides by removal of the focal lesion.

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MEDICINE AND ECONOMICS

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" Chaos umpire sits
And by decision more embroils the fray."
—*Paradise Lost*.....

Medicine is a science which studies man, especially abnormal man, seeking cause and effect in such abnormalities, and means to prevent such causes or alleviate such effects. Medicine, however, is not only a science. It is a profession; it is a means of livelihood; in some cases it is merely a business. Therefore, medicine, the practice of medicine, is a commodity, a commodity which the lay mind does not buy because of its scientific value, but because of the desirability of a particular physician or hospital. In recent years we have heard much of the desirability of formulating proper methods of buying and selling this commodity. Because the desire for this commodity is based on varied emotions and varies with location and person, much autistic thinking about its selling has resulted. Economics and economists have interested themselves in this commodity, but in so doing have overlooked the fact that medicine is not merely a commodity, but also a science.

Economics is defined as the science of the production and distribution of wealth (i.e. commodities). However, it too often loses its scientific character when it deviates from the strict study of cause and effect, and indulges in "wishful", autistic thinking, seeing a relation between cause and effect only when such a relation is suited to the desires of the group addressed or when it suits personal bias. Too often the effect is ascribed to the wrong cause in order to make laws fit particular circumstances. We are always easily convinced of truths which coincide with our preconceived opinion. Because of this looseness in the application of scientific principles in economics, much of its study and concern with the commodity medicine is valueless, useful only to groups who wish to have certain effects follow certain causes in the buying and selling of this commodity. Because medicine as a profession is not strictly a science, there is much discussion as to the relation between medicine and economics. Economists, believing themselves always strictly scientific, seek to apply cause and effect rules to the practice of medicine as a commodity; but medicine, being much less than absolute science and much more than a commodity whose value can be measured in terms of money or trade, cannot be so studied, whether the economist be rigidly objective, or loosely rationalistic. Economics is too prone to forget that it is only a small part of that body of knowledge with which medicine is daily concerned. Economics is a part of sociology, and sociology is a part of medicine.

Society is a complex grouping of individuals bound together by certain laws, desires, emotions, necessities, etc. The study of society is sociology, but because it deals with immeasurable data which cannot be fixed, formulated, and held in general laws of cause and effect, it is not strictly a science. Economists dealing necessarily with much of sociology are too prone to assume that the laws of sociology are fixed and absolute and therefore applicable in economics. Especially is this true in that branch of sociology, the study of government. Because society has formulated government in order to control the individual, and because economics deals with the forces (wealth and its power) that act to control the individual, economics has made the mistake of supposing government and economics to be the same. But whereas economics is static (if it is a true science, its laws must hold continuously, i.e. statistically), government is never stable or static. There is a constant variation between complete individualism (anarchy) and a complete subordination of the individual to the interests of the community (socialism). The laws of economics may produce different results in different forms of society, but they neither produce these different societies or are changed by them. Economists instead of dealing strictly with the laws of production and distribution of wealth are too prone to confuse government with economics. As a result economics is political rather than scientific, and therefore only valuable as it is of use to the political hierarchy.

Government and economics, whether anarchis-

tic, capitalistic, or socialistic, are political and assume that organization is the key to the further improvement of any activity and society. The assumption is made that any activity or field of endeavor not organized is *a priori* inefficient and inadequate, and therefore to be organized and administered for improvement. The recent discussions of medicine and economics are full of this *a priori* assumption, which implies that medicine because it is not organized (speaking of it as a commodity) is inefficient. This does not necessarily follow, but it is hard to convince anyone that any activity might not be improved by organization in this machine-age. We forget that organization is the means to an end, not the end itself. To organize industry where such definite resources as iron, coal, steel, oil, rubber, railroads, etc., can be exploited and developed by credit and money, where the aim of achievement is production with the least expenditure of energy and cost, then organization is the valuable means to improvement and success. But in medicine we are not dealing with such calculable and measurable resources of energy and cost. We are dealing with the resources of human energy, human emotions, and human nature. These cannot be quantitatively mined and poured into hoppers to produce a certain product which will be the same everywhere. A highly developed organization and system of machines will not produce the same commodity everywhere if the commodity is the practice of medicine. Man cannot be measured in physical terms only and no organization can adequately predict or depend on his psychic and emotional energies. Organization may curb or suppress human energies, but it cannot use them to produce a standard commodity, if that commodity is the practice of medicine.

In the organization of man (the organization of society, government), there are two attributes which it would seem desirable to preserve. In certain societies, this is debated. In Germany and Russia these qualities are suppressed, but by their suppression carry in them the seeds for the eventual overthrow of such organizations. The long history of man is the story of the deliverance and preservation of these attributes from suppression. They are: the freedom of the intelligence (and therefore of action), and the preservation of motivation for man's emotions. Man cannot stimulate himself (or but rarely) and competition, the challenge to the ego, is the only motivation known which is lasting and enduring. Without competition, whether it be with nature or with man's own organization of himself, the human organism stagnates, biologically and psychologically. In any extreme degree of organization such as a completely capitalistic or completely socialistic state would be, these attributes would be entirely suppressed, and man would fall into two classes, the rulers and the ruled. Today these attributes are being more suppressed with each change in the social economy.

These attributes are threatened by the trends to extreme organization such as are seen in the corporate state which is Italy or the socialism which is Russia; and such organization for the sake of organization is growing by leaps and bounds in our own government. This trend is not the result of rational planning, but of necessity. It is the result of the so-called "industrial revolution." Man used to be an independent economic unit, but with the development and increase in industrial organization, he has found that his independence of action, and to a great degree his independence of thought have been curtailed or obliterated so that his ability to earn a living, his pleasures, even his health have been taken out of his hands and made a part of the organization and system of government. Concomitantly, he has been given a better education and higher standards of living, so that there is a conflict and often an impasse between the constant desire for better things and an inability to get them by his own efforts, no matter how conscientiously or hard he tries. Is it any wonder that we turn to the government or highly organized forms of industry to supply these wants and satisfy these desires? Yet government and organized industry exact a further curtailment of our independence of thought and action in return. Thus it is that these two desirable attributes are being stifled; but stifled and suppressed over the protests of those who value their own individuality and intellectual freedom. A balance between self-interest and social organization is therefore necessary; there must be a mean between the highly organized state or industrially organized society and complete self-interest where the best interests of society and self are served. Only by

attaining such a mean can we preserve these attributes of freedom of intellect and adequate motivation. Both of these attributes are paramount in the practice of medicine, whether it be considered a strict science, a profession, or a purchasable commodity. Medicine as a profession, as a commodity, will be changed as the changing and organizing of civilization continues, but if it is to remain a science, it must preserve its freedom of intellect and motivation. The buying and selling of this commodity may be put on a different basis with each change in the social and political economic order, and it is therefore important to understand the changing position of the physician in the present and near future social order.

A few years ago it was reported that the total expenditures of this country for health was about three and a half billion dollars per year. This was the signal for much discussion as to how this cost might be cut and service maintained or improved, and the first consideration was the organization and regimentation of the medical profession by means of health insurance and state medicine plans. There arose much protest about this high cost of medical care and it was felt that by organizing physicians and dentists this high cost might be cut. Because of the manner of presentation in the press, the medical profession was considered a mercenary, grasping group seeking its own enrichment. A few facts, however, were forgotten and never emphasized. In the care of the sick in this country it was estimated that one and a half million persons were concerned. Of these 150,000 were physicians and 65,000 dentists, that is only one-sixth of the total. Of the total three billion and a half spent, physicians received approximately $850,000,000 and the dentists $350,000,000. These two figures represent about 32% of the total, or 23% of the total to physicians. Assuming that by organization of the physicians and dentists fifty per cent of the costs might be eliminated (and such an assumption is quite optimistic), the saving on the total bill would amount to about sixteen per cent. It is apparent that a reduction of the high costs of medical care should not begin with an organization which can save only sixteen per cent, and control only one-sixth of the total number of persons involved, at least not if we are to consider ourselves good executives and able, scientific economists. We ought first to consider the most expensive items on this bill. In this country there is spent annually one billion and a half dollars for patent medicines, quack physicians, irregular medical cults, etc., whose only function is the temporizing with physical complaints. These are all unorganized, expensive, and productive of much greater profit to those exploiting them than is the commodity medicine. They make no return in actual curing and prevention of disease for the vast amount spent on them, yet we hear nothing in the contemplated plans for the organization of medicine which will either regulate these practices or relegate them to a position of proper importance. It is notorious how lax Congress has been in the enactment of pure food and drug laws, and how easily most of these cults can influence state legislatures to make their limitations quite indefinite. If the public can waste one and a half billion dollars on those medical luxuries every year, when their return for value spent is questionable (and in depression times the public turns from the physician to self-diagnosis and self-prescribing, usually of expensive concoctions of diluted pap), is it rational to hope that organization of physicians and dentists will decrease this large part of the costs? A public which insists on such expensive self-indulgence does not need sympathy from philanthropic economists and help from an organized medicine as much as it requires education.

In handling a commodity, such as medicine, there are usually only the producer and the consumer, with occasionally a distributor in-between. The commodity is one which the consumer, the patient, demands. This demand has heretofore been a demand based on need. It is conceivable that this demand might be stimulated by education to the knowledge of how much more need there is for this demand, or it might be stimulated by advertising a fictitious and harmful or unnecessary need, such as is done in almost any newspaper by the quacks and pseudo-physicians. Advertising usually stimulates the consumer's demand by subtle lying, and therefore has always been rejected by medicine, for under it the ablest liar would be the best doctor. It may be true that the average American does not make full use of the facilities of medicine, but to force him to use these facilities by organization and its compulsion would require advertising rather than education to a felt need. To enforce the con-

sumer's demand for a commodity by such plans as state medicine or compulsory health insurance would be to further suppress the attributes of individuality and motivation.

Another fallacy about the high costs of medical care is the assumption that specialism in medicine is the cause of such high costs. In one sense it contributes to the high costs, and the medical profession is much to blame for its emphasis on specialization and the readiness with which it turns diagnosis and treatment over to a series of specialists who know only one thing and nothing else. From eighty to ninety per cent of the illnesses that occur, and practically all the preventative measures used are within the knowledge and skill of a competent, efficient, properly trained practitioner who is not too lazy to handle and solve his difficult cases. It is the duty of the medical profession to supply such practitioners. If then the public still insists on its emphasis on specialists and desires the expense of a specialist for sunburn, another specialist for a cold, and a corps of them for every vague headache when feeling the need of attention, it should pay for them and be glad to. The public should demand that it be furnished physicians who can handle competently that eighty to ninety per cent of its ills, and who know what ills should fall to the care of specialists. The medical profession itself is in a better position to define what such physicians should know and how to educate them. Organization, state medicine, can not guarantee a high quality if it will crush motivation and individuality.

It has been estimated that seventy per cent of the families with an income of $1,500-$2,500 per year spent about $100 a year for medical care, about six per cent of their income. It is obvious that with proper family budgeting such a six per cent expenditure could easily be met. Of the other thirty per cent in that income group, one half spend more than $200 per year, and for these the expenditure is often burdensome and excessive, usually because it represents the costs of unexpected illnesses requiring hospitalization and surgery or other specialized services. For this fifteen per cent the attack would seem to lie in the insurance against such special costs, viz., hospitalization, x-ray and surgery. Various plans are now being studied throughout the country and much experience being gained in the field of hospital insurance. This, of course, is usually limited for the amount of service rendered is based on the unit of insurance carried and all eventualities are not cared for. To force the public to spend more than six per cent of its income for health each year (even though we believe that it should) is to force on the consumer a commodity whose sale should be regulated by desire. This desire should be stimulated if necessary by education, such as comes from public health services and physicians themselves. The individual physician is limited in this respect because the physician who urged his families to spend more for health would be in a questionable position; but the physician through his county societies can do much to educate the public to what constitutes adequate and good medical care. If then the seventy per cent of the low income group spends six per cent of its income a year for health (an expenditure easily within its means) what is to be gained by compulsory insurance or state organization of medicine in which the costs would be increased by the bureaucracy which develops in any theoretically non-profiting organization? It is objected by all the philanthropic economists that six per cent is too low a figure for health expenditure, and that it is low because it costs too much, but this is doubtful; it is rather that the American public believes six per cent to be an adequate figure, for it will spend more for things it values more, such as automobiles and motion pictures. One cannot bribe or force a consumer to buy a product which has been cheapened below the level at which the producer can turn out a product of quality. As individuals we ought to reserve the right to say whether or not we had rather spend fifty dollars to have our tonsils out or buy a radio, for the pleasure of the radio and the punishment which may result from the diseased foci of infection are each no one's business but our own.

One more point needs to be considered in the discussion of the organization of medicine by insurance schemes, whether it is to be privately or state controlled. To provide insurance certain essential requirements are recognized. Firstly, the insurance must be limited to a field which is narrow enough for the obtaining of figures from which reasonably certain estimates of probable losses can be made. In the field of medical insurance we are as yet unfamiliar with the actual cost, as is witnessed by the report on the cost of medical care. Secondly, the field of the insured must

be wide enough so as not to destroy the reserves of the insurer in case of disaster to one part of the whole body of the insured, yet the field of medical insurance dealing only with sickness cannot guarantee that the reserves will not be destroyed. Thirdly, some mechanism must be provided by which the insurance is sold with knowledge and skill so that it may be adapted to the needs of the individual. How can state medicine guarantee this when it comes more and more to disregard individuality? Fourthly, much capital is needed so that sufficient reserves to cover any eventualities may be set up. If the state is to furnish the capital it can only do so by increasing the cost of the insurance while lowering the pay for services, and services would be rendered by those in favor with the political party in power. Moreover, what private groups would be ready to furnish the large amount of capital necessary in such a risky field of insurance? Lastly, the insurer must not enter the business of replacing losses in kind, but only of replacing funds for such losses. An insurance company does not manufacture new automobiles to replace those wrecked; by so doing it would be entering a field of activity foreign to it and which is being done more effectively and efficiently by others. Similarly, medical insurance should only guarantee funds to replace losses entailed by sickness, etc., but all schemes proposed so far would guarantee services in kind, which would assure us of greatly increased operating expenses. It is foolish to assume that any amateurs, and in this respect the state is quite an amateur, can nonchalantly enter the field of insurance and accomplish things that professional insurance organizations are still attempting and studying after a hundred years. Why will the leading insurance companies not deal with sickness insurance? To suppose that to remove the profit from the field of medical insurance would lower its cost is silly, for it would also remove the expert in insurance from the business, and the lowering of cost would be offset by the increase in inefficiency. We should be exceedingly careful in studying insurance before we attempt to apply it to the field of medicine.

If then the actual cost of health to the public is not so excessive as has been proclaimed, but is due to its own foolish spending of pennies for whistles; if by proper budgeting for the ordinary eighty to ninety per cent of illnesses it can be properly cared for, and if the other ten to twenty per cent could be cared for by forms of hospital insurance, etc., it would seem as if much could be done to keep the sale of the commodity, medicine, on an individualistic basis. To educate the public is necessary, both against its own foolish expenditure of a billion and a half or more for nostrums and quacks, and against the difficulties, expense, and bureaucracy of general medical insurance. In return for its individuality medicine must have a respect for intelligence and truth. It must adapt itself to changes in the social order. It must have profound knowledge, keep a keen and open mind, and adhere rigidly to truth, all this tempered by an intense sympathy for and charity to the other members of society. It must keep itself unsmirched with the rampant materialism, which seems to be growing within it. If the public, inflamed by the philanthropic economists, insists on the buying and selling of this commodity according to chain store methods, state medicine, etc., the medical profession must insist that it have the majority in those groups which will plan such methods. It must insist that not only medicine, but all the quack systems and all the patent medicine luxuries be brought under the same control; moreover, those luxuries of our industrial social order, such as automobiles, the radio, banking practice, and stock selling be similarly regimented and organized.

Nothing has been said about the indigent. If at present twenty per cent of our population is indigent (such an estimate will depend on anyone's definition of indigence), it is evident that one-fifth of the population cannot pay for any medical service. Until government and society are so constructed that the economic status of all is improved (and not by any fantastic Share-the-Wealth-Plans), the medical profession still stands as always that its services to the indigent are free of charge. As always the degree to which this free care is supplied is little understood by the public or its self-appointed representatives, the philanthropic economists. It would be a conservative estimate to say that in Florida the medical profession annually supplies free services to the value of $3,000,000. If the profession is not doing enough in this direction, it needs only to be reminded that it is being derelict and correction will result; but in so doing the philanthropic economists, who recommend that medicine do something for the indigent,

should remember that it is only fair and just that this contribution and the sacrifices entailed be matched, both in monetary and spiritual value. Instead of donating millions of dollars to investigations as to how medical service might be improved by organization, it might be well to subsidize the medical profession in its struggle to maintain its high principles. All through the depression, there were many physicians who were doing more free work than pay work, a condition not due to the fact that medicine needs organization, but because our industrial organization has fallen down because of its own lack of principles. Medicine and economics are related, but it is evident that neither understands the other.

COMMENTS ON BLOOD TRANSFUSIONS

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During the past several years there has been a gradual change in methods of blood transfusions, the pendulum swinging from the direct to the indirect method. With this change there has been a corresponding increase in the demand for blood. The reason for this is threefold: first—we no longer wait until a patient is about to die to use this all important therapeutic measure; second—the procedure has been simplified to the point that it is very little more than the administration of an ordinary intravenous medication; third—indications for transfusions are more numerous.

I shall discuss the indirect method used by Wenzel and Hammer[1] which I have found to be most satisfactory. I have modified this method so as to avoid the stirring of blood, which I think is of distinct advantage. This method has several advantages over our old method of obtaining blood in a beaker, citrating by stirring and pouring through a gauze filter into a bottle for administration to the recipient. First, no stirring is necessary. (This I think will reduce the number of reactions because cells are not broken up as they are by the old method. Most of us are prone to stir blood too vigorously.) Second, there is no pouring of blood from one container to the other, hence less chance for contamination. Third, the system is practically a closed one, hence the chance for air contamination is decreased. Fourth, the donor is unable to see the bottles when blood is collected and there is no blood dropping which he can hear so the psychic element is removed. Fifth, this apparatus can be packed in a sterile container, taken to a home and a transfusion given with very little more trouble than if the procedure were done in a hospital.

PROCEDURE

Using a regular vacoliter bottle, connect a Y-shaped glass tube to the distal end of the rubber tube as shown in picture. Attach a short piece of rubber tubing to the open end of the Y tube. The other end of the Y tube consists of a glass adapter to which a standard-size needle can be attached. Suspend the vacoliter bottle



Blood drawn from donor.



Blood given to recipient.

lower than the donor's arm, as shown in diagram, by a rather coarse wire. Insert about 5 or 10 cc. of sodium citrate through the open end of the Y tube. The remaining 40 or 45 cc. of citrate will be used after the blood has begun to flow.

Sterilize donor's arm with iodine and alcohol. Apply blood pressure cuff to upper part of arm and make pressure to about 80 degrees (diastolic pressure). Inject two or three drops of 1% novocaine intradermally over vein to be used. Disconnect the hypodermic needle used for novocaine and connect a No. 15 needle to syringe. Insert needle a short way into the vein and let the pressure drop so as to change connection without much loss of blood. Connect the needle to the adapter and again raise pressure to 80 degrees. When the blood is flowing freely connect 50 cc. syringe with sodium citrate to other end of Y tube and gradually allow it to flow in. At the junction of the Y tube the blood and citrate will mix.

Care must be taken not to have too tight a connection for the sodium citrate syringe because a vacuum will be created in that part of the Y tube and the citrate will be too rapidly drawn from the syringe. Another point to bear in mind is to have enough citrate remaining at the end of the procedure to citrate the blood in the tube. When the desired amount of blood has been obtained, clamp off the tube and remove needle from vein. Inject remaining citrate and open tube again. Now all the blood in the tube is citrated and the system can be disconnected from the wire hook and taken to the room of the recipient.

In giving this blood to the recipient, proceed as in giving an ordinary intravenous vacoliter. It has been my experience that a No. 17 needle is most satisfactory. It allows the blood to flow at a moderate rate. Using a small amount of novocaine as in the case of the donor, insert the needle well into the recipient's vein. Connect to the adapter and remove the clamp from the main tube and attach to tube through which was introduced the citrate. Should the patient be dehydrated, additional fluid may be given. The tube may be disconnected and a vacoliter bottle of fluid connected and given in usual manner.

In conclusion, I wish to say that I have found this method most satisfactory. I have given several transfusions with it and thus far I have had no unfavorable reactions nor any clot formation in the apparatus.

REFERENCE

1. J. F. Wenzel and H. J. Hammer: New Method of Indirect Blood Transfusion. Am. J. Surg., Oct., 1936, p. 119.

PEDIATRIC FALLACIES*

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In preparing a paper of this type, it is with a full knowledge of its iconoclastic nature and with a realization of the consequences of its delivery. Most of the ghosts that I will attempt to lay are time-honored dogmas of the laity. Many, especially the therapeutic elements, are in use by the physician doing general medicine and many are dear to the heart of the pediatrician himself.

Lest a misunderstanding exist, I would like to emphasize at the start that there is no axe being sharpened, there is no intention of teaching a lesson, there is no attempt to criticize those who are possibly in a better position than I to evaluate different practices.

The material contained herein happens to be opinions of my own, supported by what little I am able to glean from the medical literature of today and I assure you that the preparation of such a paper is approached with a proper and complete humility and trepidation. Nevertheless, I feel in my own mind that there exist many features in common use in the diagnosis and treatment of conditions in children which, if not actually detrimental to the welfare of the patient, at least lead us off the path and cause unjustified delay. A great many times this is due to the pressure that is brought upon us by the family's insistence on a quick diagnosis and vigorous treatment. Few of us have escaped that intuitive feeling that if today we continue to lack a diagnosis, tomorrow we will suffer the humiliation of dismissal and we give in no uncertain tones a name to a condition that we are much less certain about than our finality would justify, excusing ourselves by the assurance in our own minds that, regardless of what the pathology, the patient will improve.

This perhaps is excusable under certain circumstances. There are many people, and I do not exclude the intellectuals, who are so uninformed as to believe that all conditions are equally easy of diagnosis and feel that all of us should be able

*Read before the Pinellas County Medical Society, St. Petersburg, Jan. 15, 1937.

to differentiate this from that at the first visit, gauging the physician's capabilities not by his thoroughness but by his speed and the finality with which his opinions are expressed. I think there is none of us who at times has not given a diagnosis "of satisfaction" and then proceeded to work the case out until sure of himself. The average layman, in the words of the street, "won't take 'no' for an answer." Anything else will do and he will cheerfully accept a change in diagnosis three days later, while if he is told that the condition is obscure and three days will be needed for "working up", then tomorrow we are off the case. There comes a time in every life when the state of emotion supplants that of reason. Serious illness of our children makes all of us irrational, unreasoning human beings, willing to grasp at the first straw that spins in the wind, and that patient is no less to be excused than is the physician upon whom the screws are tightened.

Probably the most frequent fallacy, particularly with the laity, is the belief that febrile conditions may result from eruption of the teeth. It is possible that just previous to its eruption a tooth may be the cause of some fretfulness on the part of the infant although I doubt this for, it is reasonable to believe that, if one tooth provides trouble, he should be equally disturbed when another arises. But to believe that a perfectly normal physiological function should produce hyperpyrexia seems absurd; no more reasonable than that deposition of calcium in the epiphysis should cause trouble or that eruption of the permanent teeth should cause a like disorder. All of us have had infants presented to us with submucous accumulations of blood the size of a small pea over and around the erupting tooth, in a docile, healthy, uncomplaining youngster, in whom only the observation of the mother has led to any idea of trouble. If this major occurrence causes no disorder, why should the simple emergence or nonemergence indicate a seat of pathology generalized in character?

It is true that infants are subject to more trouble in the period extending from the 6th to the 24th month than probably at any other time, during which period most of the teeth erupt. There are, however, many other factors that influence this situation. Their contacts become more frequent than during the preceding six months, which means that their chances of acquiring the common cold are enhanced. Also, during this period, many infants are weaned from their mothers' breasts and are placed upon cow's milk or some derivative and upon accessory foods, with the added danger of ingestion of harmful organisms from the outside. Probably of all pathogenic affairs, mistaken during this period for teething, the upper respiratory infection is the most frequent. And let it be emphasized here that this infection in a year-old infant may be quite an explosive type of affair, not only from its febrile manifestations but from its frequently accompanying diarrhea and vomiting. How many times have all of us seen the child with a nasal discharge, a red throat and a high fever only to have the mother explain that the child is "just teething" because he puts his hand in his mouth. Invariably if the temperature is high enough to destroy the balance of the central nervous system and produce a convulsion, the statement is more emphatic. About five years ago I was called to a case in which a previous physician had concurred in the mother's diagnosis of teething because the child had had three convulsions. On departing he left the familiar instructions to give one pill every 15 minutes until all were taken and with the assurance that as soon as the medicine had taken effect the patient would be all right. The child had a tuberculous meningitis in which we recovered the organisms from the spinal fluid, but to this day the mother feels certain that teething at least lowered his resistance to the point where he could not throw off the organism. The physician, needless to say, did not belong to this society. That teething lowers the resistance is a frequent assertion, even sometimes seen in the text books, but no one has yet come forth with any evidence of an investigative nature to justify the statement that any immunity he may possess toward other diseases during these six months is due in any way to the fact that he has no teeth.

Another correlated fallacy concerns the lancing or rubbing through of the tooth for some reason to which its non-eruption is attributed. Aside from the very possible factor of infection the practice is to be condemned, if for no other reason than the fact that the gum is inevitably traumatized far more by this process than any arising from its natural piercing of the gum. Most of us condemn heartily the teething ring, yet some are willing to insert in the baby's mouth a far more lethal weapon, the physician's finger, than whose finger I know of none more danger-

ous. Even if surgical asepsis and antisepsis were practiced there is always left a raw or traumatized area for the transplantation of bacteria which may be benign upon, and decidedly malignant below, the mucous membrane.

Worms. Next to teething in the minds of the laity, intestinal parasites rank first in importance in the explanation of deviations from the normal. That worms do infest the gastro-intestinal tract and that they do at times cause irreparable damage can in no way be contested. But as an explanation for gritting the teeth, sleeping on the hands and knees, picking the nose, and convulsions, the diagnosis is worthless. One time-honored symptom is of some value in leading us to suspect one type of parasite and one only. That is restless sleep and anal itching. Frequently this may be due to Oxyuris which have left their normal abode, the colon, and have attempted residence in the vagina or the folds of the anal mucosa at which time their vermiform movements may cause itching and consequent restlessness. In the mild infestations certainly the vast majority of diagnoses are made by finding the worms or segments in the routine examination of the stool for ova. The heavier infestations, seldom encountered save in "back woods" communities and then usually uncinarial in type, will undoubtedly give symptoms, usually marked anemia, malnutrition and enlargement of the spleen. But as a diagnosis to account for convulsions, high temperature, lack of or increase of appetite, it is completely useless to my mind either as a primary or secondary cause. That either the movement or fixation of the parasite in the intestinal tract or the toxicity of its excreta will result in sufficient stimulation to produce in the presence of other factors a convulsive imbalance of the central nervous system may be possible. I do not know, but to me it seems highly improbable, just as improbable as blaming the same convulsion on irritation of the intestinal tract by the piece of undigested carrot that appears so frequently in the stool.

In connection with the worm situation, I would like to criticize the use of the vermifuges that appear under various trade names such as Dr. Hands', Dr. Jones', etc. In my experience these mixtures are no more than rather drastic laxatives with an insufficient amount of specific medication. They are seldom of any value in ridding the child of the particular parasite that he may have and in addition by frequent and prolonged use they may set up chronic inflammatory processes. Many of you, I know, have had experiences such as my own in which oleoresin, carbon tetrachloride, hexylrescorcinol crystoids and several other agents have been used no less than 8 times in an attempt to rid a patient of Taenia saginata, only to find eggs still in the stool at the last examination. How utterly hopeless to attempt the same thing with a shotgun mixture of oleoresin, santonin and quassin. If the child is infested, this should be verified by stool examination or observation of the parasite; the patient should be vigorously treated with the specific drug, and then rechecked after an interval of time.

Constipation. Of all the problems encountered by the pediatrician none is met more frequently, causes more disturbance in the minds of the laity, or is harder to control, than constipation. Nor is there in many cases any harder problem to solve than its causative factor. A discussion of the various factors leading to this condition is, however, foreign to the object of this paper. My main purpose is a friendly criticism of the general methods of control of the situation and the hope of relieving some of the stigmata and fears associated with it. Constipation, like teething and worms, has been blamed for everything under the sun. That it may produce some discomfort in a young infant I think is true, but it is peculiar that so many chronically constipated infants are without pain or the time-honored complaint of "gas". It is undoubtedly true that some children will have considerable pain in passing a large hard dessicated fecal mass and will sometimes rupture one of the small vessels in the lower rectum and hence present bright red blood with the stool. That constipation in itself produces fever, "auto-intoxication", or vomiting is a rather futile explanation in the light of an article recently published in the American Journal of Pediatrics. Dr. Irving A. Frisch took 17 children, 13 of whom were perfectly well, and four in a convalescent stage of rheumatic fever. By giving fairly large doses of paregoric, he was able to produce an almost unbelievable state of obstipation. On the average, these children had one bowel movement every 11 days. Two children went over 25 days and one over 29 days without any movement at all. Careful observation of all of them in regard to temperature, blood count, sedimentation rates, blood chemistry including blood indican showed

no variation from the normal. The urine contained a good deal of indican. The basal metabolism on two children was normal. The x-ray showed normal gastric motility and of course large masses of impacted fecal material. Their general reaction was normal, no logginess or other evidences of morbidity being present. I have myself seen any number of children who had not had bowel movements for three or four days without any interruption of their normal activities. In fact, with the artificially fed infant a moderate constipation I consider as a normal and safe condition and advise no interference, inasmuch as the usual means of interference tend to produce a habituation to either laxatives or mechanical stimulation. My observation has been that a great deal of the constipation seen in infancy is due to the fact that the mother firmly believes that the child should have two, or at least one, bowel movement daily and if he does not, resort is made to the suppository or enema can, the result being that the child is never allowed to approach the normal stimulus for evacuation. My advice, (I must admit, seldom followed) is to allow the baby to proceed for at least 48 hours before resorting to other means for producing movement. I feel, in the long run, that one bowel movement produced through natural effort is worth a great deal more than any number secured otherwise and that if left alone the majority of infants will regulate this feature for us.

To digress for a brief moment, I would like to mention two outstanding causes for the condition existing in young children. The most frequently overlooked, in my experience, has been a relatively tight anal sphincter which incidentally can usually be remedied by the insertion of the finger, beginning with the little and increasing about once a week until the index is reached. This should be done daily and preceded by careful lubrication of the finger used. Severe trauma occasioned by forced manipulation is to be avoided. Another type characterized by the hard, dry, ball-like, so-called "billy goat" stool is most frequently due to either a lack of fluids or an excessively rapid rate of absorption and can usually be benefited by increasing the fluid intake.

Colic. Of all the conditions that weigh heavily on our shoulders that produce madness, delirium and bad dreams for the mother, the father, the family and the physician, this reigns supreme. Unfortunately it is at its worst at the one time that we want peace and quiet and uninterrupted rest for all—the return from the hospital. The grandmothers have called it "the three months' colic" which is a rather apt term for, usually, regardless of what is done or not done for relief it seems to improve spontaneously at the end of this time. But three months can be an exceedingly lengthy time with a day to day report of no improvement. Like pertussis, its multitude of therapeutic agencies reflect the lack of any specific remedy. As far as that goes, the same thing may be said of its etiology. Underfeeding, over-feeding or poor feeding has very little to do with it except as a supplementary factor. Certainly, the baby with colic will suck on anything that is put in his mouth, no matter how full he may be, in the hope of relief from his suffering, and accordingly his stomach may become distended and add to his already present discomfort. There are many things in favor of the theory of Dr. Moore of Dallas, who contends that it is another condition to be blamed upon allergy. Certainly we find a preponderance of it in families with an allergic background and many eczema cases are accompanied by colic. The most substantial proof, however, is in the fact that the change from mother's milk to some form of other animal milk, or the change from cow's milk to goat's milk or so-called non-allergic milk will often prove beneficial. There is, however, very little in favor of the change from cow's milk to Recolac to S. M. A. or other cow's milk derivatives inasmuch as they all contain the same cow's milk protein.

As for the various time-honored home remedies, catnip and fennel, asafoetida, grape vine tea, etc., very little can be said in their favor except that, as a rule, they are harmless and give the family something to do. Occasionally I have thought that a few drops of whiskey have provided some relief. The two drugs of most value are phenobarbital and atropine. Given over a period of weeks they undoubtedly give some relaxing effect, but I feel that their value is for the moment and for continuous relief they must be continued until the condition has remedied itself.

Calomel. To quote Blumgarten's Materia Medica, "Calomel is principally purgative in action and this action is produced mainly in the duodenum. It causes redness and increased secretion of the mucous membrane which brings

about increased peristalsis. It also induces increased contractions of the bile ducts with increased flow of bile. Calomel also acts as an antiseptic in the intestines, checking growth of bacteria." Instead of the old saying that the worse the taste of the medicine the better its effect, of calomel apparently the saying should read, the greater the indisposition of the patient the greater the effectiveness. I feel, and I am sure this is the opinion of the great majority of the pediatricians everywhere, that calomel is a dangerous drug for pediatric use. If the purpose of its use is purgation, there are many drugs, in particular the hydrogogues, that are equally as effective in completely emptying the intestinal tract. The most frequent explanation given for its use is that of "touching up the liver." Why the liver in the child needs this stimulation is one that has puzzled me for years. Certainly the old idea of biliousness as a disease entity has long ago been replaced by the terms acidosis or ketosis, which in turn we do not understand thoroughly, but at least we do know more of this than of the ambiguous terminology of the former condition. Besides, the action of calomel is not on the liver but on the bile ducts and the increased flow of bile by no means indicates an increased outpouring of toxic products from the liver. The only condition in which direct benefit is derived from the use of calomel is in acute catarrhal jaundice where there is duodenal inflammation about the opening of the bile ducts, causing interference with its normal drainage and even here the saline cathartics have been shown to be equally as effective.

The much-vaunted antiseptic action of the drug might possibly appear to be of some value in the dysenteric diseases were it not for the fact that its irritant action undoes what value it might have in destroying bacteria. But it is worthwhile to remember that it has no selective bactericidal action and that the saprophytic and fermentative bacteria are killed, probably much more readily than those of the dysenteric group. Anyway, I have my doubts as to whether it kills any appreciable number of any kind. I do know that there is marked irritation produced on the mucous membrane of the gut, interfering with normal absorption, producing excessive mucus and in many cases blood. In the diarrheal diseases, we already have enough of this irritative action produced by bacteria and the idea that purgatives can speed up a process already at top speed seems rather useless even were it of benefit to have it speeded up. In addition to this chemical irritation there is undoubtedly some toxic factor to the drug as witnessed by the fact that when given to the child in good health (some people are still of the belief that a dose of calomel in the spring, like the old sulphur and molasses, is necessary to "purify the system") he usually is nauseated, dehydrated and apathetic for a period of 24 hours. This is entirely aside from the known and ever-present danger of true mercurial poisoning which is not infrequently encountered. In short, the drug has emphatically too many dangers, at least in dealing with children, in contrast to what little virtue it may possess.

Castor Oil. This drug, while not subject to the criticisms of calomel, in many ways acts likewise to increase trouble already present and many of its customary uses with children I do not think justified. Particularly is this true of its use with icterus neonatorum. The laity and many nurses, particularly the genus practical, will insist on a dose of castor oil about the fourth or fifth day of life and then will with a triumphant air present you with the stool filled with mucous bile and flakes of blood exclaiming "look what the castor oil brought out of him", never stopping to reason that it had not so much brought it out of him as it had by its irritant action produced it. Among other features in infants it produces a griping type of peristalsis that nearly always results in two or three hours of crying and then leaves him more constipated than before.

Throat Swabbing. In approaching such a deadly subject of controversy it is with trepidation and the fear that in the end I will be outargued by the ear, nose and throat delegation. Again, I emphatically state that it is merely my own opinion that it is a bad procedure to adopt, at least routinely, especially with children and I am not trying to educate some one out of his own choice of methods. The ordinary throat infection, whether it be the relatively benign, slightly swollen and reddened pharynx or the intensely engorged, fiery red throat covered with exudate, is never a mere surface manifestation. It involves not only the surface mucous membrane but the adjacent muscular and connective tissues and extends deep into the lymphoid tissues of the tonsils and adenoids. Hence, swabbing touches nothing but the surface of trouble,

analogous to my mind of wiping mercurochrome over a furuncle. The role of nature has been canonized and greatly overworked in her maternal solicitude for and protection of her favored offspring, the human race, yet we can say without any question of being confounded that with the ordinary inflammatory processes her ability to wall off with protective material far surpasses anything that we can do with our comparatively limited means. We are warned and adjudicated to leave alone the boil until it is thoroughly localized; to do likewise with the ruptured appendix that shows any tendency to becoming walled off; to apply hot, wet dressings to the acute cellulitis to facilitate this same process; yet when our tonsils are afflicted with a like infection we step in and massage them with cotton on the end of a stick. With the adult, perhaps medication may be applied in such a way as to produce no tissue trauma, but I defy the operator, no matter how skilled, to attest that his swabbing has been without tissue injury when he has a screaming, struggling two-year-old child to contend with. And frankly it makes me shudder when the mother announces that she has been swabbing Johnny's throat three times a day but he seems no better. Most families in the presence of a sore throat insist on measures directed toward treatment of the throat itself. In older children gargling with various mild antiseptics may be employed and with the younger argyrol may be instilled in the nose with the statement that it gets down into the throat. Neither is of any value whatsoever but, on the other hand, neither is the least bit harmful. In pediatrics the throat infection comprises at least 50% of our practice. We see it treated every way; vaccines, swabbing, gargling, ice or heat to the throat or what have you. I feel certain in my own mind that these patients recover most quickly if the throat is untouched. A little aspirin, I think, makes the child feel better and the use of fluids internally and externally, respectively, dilutes the absorbed toxins and gives some relief from the discomforts of high temperature. Incidentally, I allow these patients to eat anything they desire and when the appetite is very poor, as it usually is, insist on lump sugar, stick candy or lollipops in the belief that these simple sugars are easily assimilated and prevent the exhaustion of glycogen reserves with its consequent acidosis, so frequent with any febrile disorder of children.

Diet. We are so situated in St. Petersburg that we get a composite of the whole U. S. in diet and therapy and, I should say, diagnosis. Some are good, some fair and some awful. This is particularly true of children's diets. We see one that allows no meat, another in which bacon is prescribed at seven months but ham is abolished until puberty; another in which proteins are given ad lib. but sugar in only minute and measured amounts, and still another which is void in fats. We have all, of course, experienced in our immediate midst the uncooked vegetable fads as well as the food combination fads. The net result is a very firm admiration for the intestinal defenses in infancy and childhood and the conviction that observance of a few essential rules will eliminate 95% of the gastro-intestinal disorders encountered in this group. Neither the variety of food nor the age at which it is administered plays any appreciable part in their origin. I have seen any number of children under 1 year of age fed pie, cake and other of the so-called indigestibles, who not only survived but prospered. I have seen babies of six months fed satisfactorily without the aid of milk. I have seen them refuse vegetables in every form and grow fat without either avitaminosis or constipation.

Today, as we all know, the field of dietetics is the land of green pastures for the quack, the charlatan and the fanatic, not to mention the food and drug distributing houses. Witness the publicity that is being showered upon the vitamins. The present administration is a piker compared to the a, b, c, d, e, f, and g's that we hear over the radio, see in the papers and magazines and even have to taste when the detail man comes around. They are presented singly and in every combination, each with its special claim to fame. We get them shoved down the throat in candy, milk and vegetables and when a more rational vehicle is not used they may be found in tablets, liquids, powders or syrups. I assure you that there will be no astonishment on my part next week if radio starts booming Triple XXX Vitamin D Bourbon Whiskey or Old Shanty Vitamin G Gin. And yet with all the fanfare, aside from vitamin D, about which incidentally there is a great deal left to be learned, we would have to employ an expert to avoid them in the average American diet. Certainly in Asia and other localities where there is usually only one staple food for consumption, the vitamin

situation may be one of immense concern but, fortunately, we don't live in China.

The one factor much more important than the prescribing of particular foods in particular amounts is that of careful preparation of everything taken into the gastro-intestinal tract of the infant or small child, which means, in a few words, avoidance of bacterial contamination, and using every refinement of technique at our command to insure this. Of all foods susceptible to contamination with and growth of bacteria none is so completely fitted for this role as milk, a food that in its production must pass through many hands or much mechanical equipment and which is in the end an ideal culture medium for most of the virulent organisms that initiate intestinal pathology. Probably no one factor has contributed more to the decrease in infant mortality than that initiated many years ago by Jacobi when he insisted on the boiling of all cow's milk fed to his infants. Today this is not as necessary for this purpose as in preceding decades inasmuch as the science of dairy supervision has insured, in the larger and more up-to-date communities, a milk that is relatively safe for consumption. But the first and foremost rule to be observed in the infant dietary is the use of food free as far as possible from bacterial involvement and where this production is uncertain, the sterilization of all foods amenable to this process. Second, the child must not be overfed, which merely means that his own wants should be regarded and the stuffing attempts on the part of the mother to bring his weight up to that of the neighbor's baby or the weight charts must be discountenanced. The converse of course is taken for granted, viz., that he should be supplied sufficient food for nourishment and growth. Third, the diet should be composed of a diversity of food products for his selection. This does not mean that because there is a diversity they must all be eaten. The best example of this is the despair of the mother whose child will not touch vegetables. Invariably this child will like fruits of all kinds and the situation is very easily solved by telling her to skip the vegetables entirely.

Observing these rules, I believe the widest latitude may be given without encountering difficulty. Fifteen years ago bananas were thought to be fatal for infants; today it is one of our favorite early foods. Pork occupies the same position today in the minds of the laity and many physicians, yet the Germans have been feeding their children sausage for many years and why the curing of the product into bacon should exert any salutary effect I am unable to discover.

In conclusion, I want to repeat my original statement that this paper is not written as a lecture on what is being done wrongly. All the material in it has been and still is the subject of discussion and controversy. If there is any moral to be taught it is for us to attempt to reason out our procedures and not accept ideas merely because they are time-honored and hoary with age, without at the same time disparaging customs that have survived the usage of years.



A letter was mailed to each member of the State Association on June 8, 1937, by the Committee on Legislation and Public Policy. This letter contained a report on the last session of the legislature concerning the medical bills. If you failed to receive your letter, a duplicate will be mailed to you on request. Address P. O. Box 1018, Jacksonville, Florida.

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The Journal of the Florida Medical Association, Inc.

Owned and published by the Florida Medical Association, Inc.

Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at Jacksonville, Florida. Price $3.00 a year. Single numbers, 30 cents.

Contributions for publication in this Journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, Inc., Box 1018. Jacksonville, Fla. Telephone 5-0577

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COMPULSORY HEALTH INSURANCE AND DISEASE CONTROL

It is the general opinion that we are rapidly approaching the time when compulsory health insurance bills will be considered by Congress and many of the state legislatures. Social workers and other politicians well intrenched and on pay from public taxes have worked skillfully during the past three years to persuade the public that they, if given the opportunity, could furnish a more adequate and a more complete medical service. The public themselves do not realize the quality of service they would receive through this mass production medical service.

Every member of this association, every thinking physician, knows that individual attention and painstaking analysis are necessary for sound medical practice. Any sensible person can understand that such service cannot be given in a "panel" practice when ten minutes is to be devoted to a patient. Then the problem is simply this: it is our duty to our patients and to the public that we, as physicians, become informed and that we pass this information of just what this brand of socialism, sugar-coated for the gullible, so-called "health insurance" really means for the public. It is our duty to tell every patient and every voter the facts and not let them be led into something blindly that will neither insure health nor control disease.

Information can be secured from the American Medical Association and from Public Relations Bureau, Medical Society of the State of New York, 2 East 103d Street, New York, N. Y. "Compulsory Health Insurance and Disease Control" is the title of a group of articles by Frederick L. Hoffman, LL.D., published and distributed by the New York State Society at ten cents a copy. Dr. Hoffman was for forty years an insurance company statistician internationally known and ranks among the foremost statisticians of the age.

The Medical Society of the State of New York employed Dr. Hoffman in the summer of 1936 to make a statistical survey of the death rate of England and Wales operating under State health insurance and compare his findings with the statistics of the same diseases treated in America under our system. Forty-seven of the most common diseases causing death were selected and compared for the year 1934.

It is interesting to note his statistics on infectious diseases because in infections prompt diagnosis and treatment and prompt isolation are necessary to secure the lower death rate. In this section most of the diseases show about half as high a death rate in America as in England under "Health Insurance."

In all the diseases studied there are only a few where the death rate in America is as high or higher than in England, Scotland or Wales. He says: "The situation may be summed up in the statement that national health insurance administers chiefly to trivial complaints and minor ailments of the upper respiratory tract superficially treated in panel practice in which the time factor is of the utmost importance.

"Compulsory health insurance endows dependence on a huge scale on public funds and public methods of relief which this country should, by all means, avoid. The social service profession, in season and out, is actively engaged in promoting state or national undertakings, and encouraging public dependence, increased bureaucracy and burdens of taxation. But worst of all, compulsory health insurance lowers the standards of medical practice, hinders medical progress and brings about the regimentation of the medical profession to virtually the standard of a labor union.

"It is to be hoped that those who impartially view the situation will familiarize themselves with the actual facts in England and Scotland at the present time and not be carried away by the complacent assurance of social service workers

who, with little knowledge of the actual facts, rely wholly upon official reports which are one-sided and incomplete."

VENEREAL DISEASE INFORMATION

"Venereal Disease Information" is a monthly publication prepared by the U. S. Public Health Service for distribution among the medical profession throughout the United States. It measures approximately 6 by 9 inches and ranges in size from 25 to 75 pages.

It is the purpose of the Public Health Service in issuing this publication to provide in condensed form a monthly summary of the scientific developments in the diagnosis, treatment, and control of syphilis and gonorrhea. More than three hundred American and foreign journals are reviewed for this work. Abstracts are made of articles describing laboratory, pathologic, and clinical work in the field of venereal diseases.

The most important literature on every phase of the subject is presented in the form of brief abstracts that are easily read. An index for the year is published with the December issue.

During the past year thousands of physicians found this publication useful in enabling them to keep abreast with developments in venereal disease work.

The cost of this publication is only fifty cents per annum, payable in advance to the Superintendent of Documents, Government Printing Office, Washington, D. C. It is desired to remind the reader that this nominal charge represents only a very small portion of the total expense of preparation, the journal being a contribution of the Public Health Service in its program with state and local health departments directed against the venereal disease.

STATE NEWS ITEMS

One of our four medical bills passed both the Senate and the House. This bill was termed the "Designation Act" and provides that each practitioner of the healing arts holding a state license shall cause to be placed and kept in a conspicuous place at each entrance to his or her office words or proper abbreviation denoting the particular kind or branch of the medical and/or material healing art he or she is licensed to practice. This bill passed the Senate on May 5, passed the House on May 19, and was signed by the Governor on May 25.

Dr. Julius C. Davis, chairman of the Committee on Legislation and Public Policy, has mailed a three-page circular letter to all of our members, giving a resume of the activities of the last legislative session. It was impossible to get material in time for this Journal. You may expect, however, to find in the next Journal, a more elaborate resume.

* * *

Dr. Edward Jelks, President of the Association, was a guest speaker at the Golden Jubilee Meeting of the Florida State Pharmaceutical Association, held in St. Petersburg, Tuesday, May 18. Doctor Jelks visited a number of the local doctors while in St. Petersburg. He stopped in Orlando on the return trip to consult with Dr. Gilbert Osincup, Chairman of the Executive Committee and Dr. W. Henry Spiers, President-elect, concerning some Association business.

Some eight or ten Orlando doctors lunched with Doctor Jelks at the Club and all enjoyed a very pleasant hour together at that time.

* * *

Drs. T. Z. Cason and Louie Limbaugh of Jacksonville were among those in attendance at the meeting of the American College of Physicians held in St. Louis recently.

* * *

The American Public Health Association will hold its 66th Annual Meeting in New York City, October 5-8, 1937. The following related societies will meet with the Association as usual: The American Association of School Physicians, International Society of Medical Health Officers, Conference of State Sanitary Engineers, Conference of State Laboratory Directors, Association of Women in Public Health, and Delta Omega.

* * *

Dr. and Mrs. E. J. Melville, 335 Third Avenue, North, St. Petersburg, recently sailed on the Thurland Castle from New York for an extended cruise through the Panama Canal to Honolulu and the South Seas following the route of the China Clipper to Manila. From there they will go to New Zealand, Australia and Tasmania, returning via the Dutch East Indies, China and Japan. The ship will return from Penang, Malaya, via the Cape of Good Hope and West Africa. The Melvilles expect to be home about September 20.

The many friends of Drs. W. R. and F. H. Schnauss of Jacksonville will regret to learn of the death of their father, Dr. Frederick Wilhelm Schnauss, in Jacksonville on April 20. Doctor Schnauss practiced medicine for 30 years at Cecil and Valdosta, Ga., prior to 1935 when he retired and moved to Jacksonville to live with his sons. Dr. Schnauss was 70 years of age at the time of his death.

* * *

Dr. Joseph Halton of Sarasota has purchased 105 feet adjoining his hospital and expects to build an addition to the hospital in the near future.

* * *

Dr. and Mrs. Lawrence A. Klein of Live Oak made an extended trip through the North during the month, attending the meetings of the A. M. A., the Associated Anesthetists of America, and several clinics in Philadelphia and New York City. Their trip lasted three weeks.

* * *

Dr. Homer L. Pearson of Miami announces the removal of his office from 1107 Huntington Building to 149 S. W. First Street.

* * *

Dr. and Mrs. Charles F. Henley of Jacksonville announce the birth of a son, Charles Frederick, Jr., on Tuesday, May 11, in St. Luke's Hospital.

* * *

Dr. Raymond Ralston of Pennsylvania has recently located in Lakeland. Doctor Ralston who specializes in internal medicine, is associated with Dr. R. R. Sullivan.

* * *

Dr. Gerry R. Holden of Jacksonville and Dr. Homer L. Pearson of Miami, two of our past presidents, represented the Florida Medical Association as fraternal delegates to the annual meeting of the Medical Association of Georgia, held in Macon, May 11-14. Dr. H. B. Rogers of Miami was also in attendance.

* * *

Dr. Francis T. Holland announces the opening of offices at 121½ S. Monroe Street, Tallahassee. Doctor Holland was formerly connected with Company 4430, CCC, Tallahassee.

* * *

Dr. L. Y. Dyrenforth of Jacksonville was elected a Fellow in the Florida Engineering Society at a meeting of that body held May 1.

Dr. R. R. Killinger of Jacksonville was guest speaker at a luncheon meeting of the Army and Navy Club on May 13. He discussed the value of a complete and exact autopsy in the solution of crime.

JAMES KNOX SIMPSON

The untimely death of Dr. J. Knox Simpson, which occurred in Jacksonville on May 19, took from the ranks of the Florida Medical Association one of its outstanding members.

Doctor Simpson, who was born in Laurens County, S. C., 51 years ago, descended from a family of prominent surgeons. His father, Dr. John Pattillo Simpson, was a noted surgeon at Laurens, S. C., and his father's grandfather was one of the first graduates of the Medical School at the University of Pennsylvania and was distinguished as a surgeon. His maternal grandfather, Dr. James Croll Knox, was known throughout Alabama as a surgeon of repute.

After finishing his pre-medical schooling at Clemson College in 1905, Doctor Simpson entered the University of Pennsylvania Medical School from which he graduated in 1909. For the following 18 months, he was at the Mayo Clinic, Rochester, Minn., where he refused an offer to become connected with the medical staff of that institution.

In 1912 Doctor Simpson moved to Jacksonville where he practiced until the time of his death, building a reputation as an outstanding surgeon. He was past president of the Duval County Medical Society, a member of the Florida Medical Association, the Southern Medical Association, the American Medical Association, the Southern Surgical Association, the College of Surgeons and a Fellow of the Southeastern Surgical Congress. He was on the staffs of St. Luke's Hospital and the Duval County Hospital. During the World War he served as chief surgeon of the U. S. Naval Hospital at Charleston, S. C.

Doctor Simpson took an active interest in the civic and social affairs of Jacksonville, devoting his time in unselfish enterprise to aid others. He was an elder of the Riverside Presbyterian Church, a member of the Rotary Club and the Timuquana Country Club.

Doctor Simpson was possessed of versatile talents and used the hands that made him famous as a surgeon to carry on his hobby as an amateur sculptor, at which work he was considered ex-

ceptionally adept. One of his works was a bronze plaque of the late Dr. Joseph G. Venable, founder and pastor of the Riverside Presbyterian Church, which he presented to the Church.

Surviving him are his widow, Mrs. Louise Simpson; three children, Louise, Anna Marie, and James Knox Simpson, Jr.; his mother, Mrs. Anna K. Simpson, and three sisters, Mrs. A. W. Cockrell and Miss Lucia Simpson of Jacksonville and Mrs. John Fewell of Greenville, S. C.

MORRIS D. HARTMAN

Dr. Morris D. Hartman, aged 48, of Homestead, passed away in Miami April 13, as the result of an automobile accident April 9. The funeral was in Nashville on April 15.

Doctor Hartman studied at Vanderbilt University and received his M.D. from Jefferson Medical School in Philadelphia in 1912, where he did two years' post-graduate work. He served one year as intern at Randall Island, N. Y., and one year in St. Louis. He was engaged in private practice of pediatrics in Nashville for a number of years, serving on the staffs of the Protestant and Vanderbilt Hospitals. Seven years ago he came to Homestead, where he made his home and practiced.

During the first year of the World War, Doctor Hartman went to Austria where he was a Red Cross surgeon until 1915, when all Americans were ordered to leave Austria. Upon his return from Austria, he was sent to the Mexican border as Captain in the U. S. Medical Corps, being attached to the First Tennessee Ambulance Corps. Upon the entry of the United States into the World War, Doctor Hartman was sent overseas with the Rainbow Division. At the conclusion of the war he was made Sanitary Inspector for the entire American Army of Occupation, with headquarters at Coblenz, Germany, with the title of Major. He served as Commander of the American Legion in Nashville and was a member of the Veterans of Foreign Wars, the Forty and Eight Club, the Elks, the Eagles, and the Lions.

His professional affiliations were with the Dade County Medical Society, the Florida Medical Association, the Southern Medical Association and the American Medical Association.

Surviving are his wife, Mrs. Helen Heilbroun Hartman, and a daughter, Miss Henrietta Hartman, of Homestead; his sister, Mrs. Juliet Burk, and his brothers, Ike, Arnold, Lewis and Victor Hartman, all of Nashville.

Dr. Hartman's outstanding professional ability and social qualities had earned for him the confidence and esteem of a large constituency in his community, of fellow physicians and a host of friends throughout the country.

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COMPONENT COUNTY SOCIETIES

DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held in Wauchula Tuesday evening, May 11. The following members were present: Doctors McSwain, Kirkpatrick, Peacock, Poucher, Spears, Bevis, Kayton, McKnight, and Martin.

Dr. N. L. Spengler of Tampa was the guest speaker and read a most interesting paper on "The Economic Status of Medicine." Doctor A. B. McCreary of the State Board of Health lead the discussion. The regular business meeting was held preceding the scientific program. The meeting was very interesting and all the doctors present enjoyed the good fellowship.

DUVAL COUNTY MEDICAL SOCIETY

The June meeting of the Duval County Medical Society, held at the Florida Yacht Club, was a combination scientific and social event. The scientific program took the form of a symposium on Arthritis, with the following out-of-town doctors as guest speakers: Dr. William C. Blake, Tampa; Dr. Spencer A. Folsom, Orlando; and Dr. Arthur H. Weiland, Coral Gables. Dr. Kenneth A. Morris, president of the Society, presided. The program was arranged by Drs. Robert B. McIver and H. B. McEuen. Dinner and, later, a dance followed the scientific and business session.

The following resolutions were adopted by the Society relative to the recent death of Dr. J. Knox Simpson:

"WHEREAS, it has pleased Almighty God in His divine wisdom and mercy to call from our midst our beloved colleague, J. Knox Simpson, and

"WHEREAS, the community has lost one of its outstanding surgeons as well as an outstanding citizen who took a deep and untiring interest in civic affairs and was an indefatigable worker for everything that was for the best interests of the community, and

"WHEREAS, the members of the medical profession have lost a wise counsellor, a willing and able teacher, a hard worker for everything that made for progress in the profession, and a courageous leader,

"Therefore, Be it Resolved, that we, the members of the Duval County Medical Society, fully conscious of the great loss of our leader, colleague and friend, do hereby offer our deepest sympathy to the bereaved family;

"And Be it Further Resolved, that a copy of these resolutions be spread upon the minutes as a permanent record, and a copy be sent to the family."

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held at Chattahoochee, Thursday, April 15 at 3 p. m. Dr. Edward Jelks of Jacksonville, president of the Florida Medical Association, was guest of honor at this meeting. The following papers constituted the scientific program:

"Intestinal Obstruction," J. C. Davis, Quincy.

"Acute Cranio-cerebral Injuries," J. G. Lyerly, Jacksonville.

"Venereal Diseases—What Can Be Done to Control or Check Them," Henry E. Palmer, Tallahassee.

"Amebiasis," W. D. Rogers, Chattahoochee.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. S. C. Harvard of Brooksville was host to the Pasco-Hernando-Citrus County Medical Society on May 13. Dinner was served at the Tangerine Hotel, followed by the scientific meeting. Minutes of the last meeting were read and adopted. Interesting case reports were given by the doctors present: Drs. Bradshaw, Cox, Carter, Creekmore, Jones, Harvard and Walters. Dr. William H. Walters of Lacoochee invited the society to meet with him in June.

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Having received from your President greetings and instruction for the new State Auxiliary year, you will follow with interest your page in the Journal shortly to include the prize winning High School essay on "The Problem of Ridding Florida of Tuberculosis." Refer to the April Journal's "Report of the Advisory Committee to the Woman's Auxiliary" for full particulars on this essay. The report of the A. M. A. Auxiliary meeting will also be forthcoming.

Since having Dr. Morris Fishbein in person at our St. Petersburg convention, interest has been stimulated in Hygeia, of which he is editor; and in the Auxiliary news page of the Journal of the A. M. A. Recent numbers bring forth these items of general interest to Auxiliary members. From Kansas a plan to aid the basic science law in the form of a petition with explanation of the law was presented to the various women's organizations. Texas shows cooperation with the P. T. A. furnishing speakers through a Public Relations Chairman on such timely subjects as Prevention of Tuberculosis; Behavior Problems in Children; Obesity; Fads, Fancies and Fallacies; Effect of Health on Efficiency. Other valuable subjects for Auxiliary meetings, Mental Hygiene in Family and Community Life; Allies of the Medical Profession; Sneezes, Sniffles and Such, were mentioned.

Washington State reports the collecting and mounting of nearly two hundred posters. They can be displayed as a whole or in fourteen different groups such as Food Values; Common Defects in Children; Posture; Good Eyesight, etc. This exhibit has been obtained from the A. M. A. or through its endorsement.

ORANGE COUNTY

Mrs. Charles Collins was elected President of the Woman's Auxiliary at the annual meeting

held in the Colonial Orange Court Hotel. Other officers elected were Mrs. Sam Ricker, first vice-president; Mrs. Frank Gray, second vice-president; Mrs. Claude Anderson, recording secretary; Mrs. Horace A. Day, corresponding secretary; Mrs. R. P. Henderson, treasurer, and Mrs. J. A. Pines, historian. Reports for the year were given by the retiring officers and members of standing committees and members who had attended the State Medical Meeting at St. Petersburg told of the work of the groups throughout the State.

Polk County

Mrs. R. L. Cline was elected President of the Auxiliary at a business meeting held April 14, in the home of Mrs. S. F. Smith, following a dinner at Armstrong's Grill. Other officers elected were Mrs. C. H. Murphy of Bartow, vice-president; Mrs. Joe M. Bosworth, secretary and treasurer; and Mrs. G. C. Overstreet, publicity chairman. Mrs. James R. Boulware, Jr., was appointed chairman of Hygeia; Mrs. John F. Wilson, chairman of the membership committee, with Mrs. W. F. Peacock of Bartow as assistant.

ADVERTISERS' NOTES

Leaflet on Preventable Diseases

To direct immunization by the family physicians a special leaflet on preventable diseases and their immunization, has been prepared by The National Drug Company of Philadelphia.

This leaflet contains brief and accurate statements on the methods of immunization carried out in protecting infants and young children against the dangerous and preventable diseases of early childhood.

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The folder does not bear the name of the National Drug Company—nor is there any reference to any National Drug product in this leaflet. It is prepared for the physician to distribute to his patients; as many leaflets will be furnished to physicians as they may wish to distribute by writing to The National Drug Company, Philadelphia, mentioning this journal.

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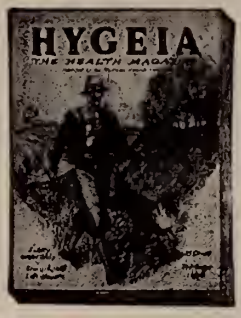
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COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	T. A. Snow, M.D., 103 E. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	19	70%
Bay	D. M. Adams, M.D., Panama City	Allen H. Miller, M.D., Millville			10	83%
Brevard	W. C. Page, M.D., Cocoa	Bob Schlernitzauer, M.D., Rockledge	3rd Tuesday	Varies	4	40
Broward	George S. McClellan, M.D., Pompano	Oliver C. Brown, M.D., 915 Sweet Bldg., Fort Lauderdale	4th Wednesday 8:00 P.M.	803 Sweet Bldg. Fort Lauderdale	29	100%
Columbia	T. H. Bates, M.D., Blanche Hotel Annex Lake City	M. W. Spearman, M. D. Morrison Bldg. Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	13	100%
Dade	R. N. Burch, M.D., 1774 S.W. Eighth St. Miami	Walter C. Jones, Jr., M.D. 802 Huntington Bldg. Miami	1st Friday 8:30 P.M.	Elks Club	213	81%
DeSoto-Hardee-Highlands	Gordon H. McSwain M.D. Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	19	100%
Duval	Kenneth A. Morris, M.D., 237 W. Duval St. Jacksonville	George W. Croft, M.D., 713 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	128	81%
Escambia	J. C. McSween, M.D., Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	33	83%
Hillsborough	George L. Cook, M.D., 442 W. Lafayette Tampa	James S. Grable, M.D., 811 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	93	94%
Jackson	C. H. Ryals, M.D., R.F.D. No. 1, Grand Ridge	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	12	80%
Lake	LeRoy H. Oetjen, M.D., Leesburg	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 P.M.	Eustis	16	94%
Lee	H. Quillian Jones, M.D., 18-20 Leon Bldg., Fort Myers	Harvie J. Stipe, M.D. 39 Earnhardt Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	11	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	L. L. Dozier, M.D., Tallahassee	B. A. Wilkinson, M.D., Telephone Bldg., Tallabassee	Quarterly 3:00 P.M.	Varies	34	94%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			4	100%
Manatee	Lowrie W. Blake, M.D., Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	12	100%
Marion	Ralph E. Russell, M.D., Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	21	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	3	100%
Orange	F. H. Harms, M.D., 64 No. Court St. Orlando	Hewitt Johnston, M.D., Box 2002 Orlando	3rd Wednesday 8:30 P.M.	Varies	54	93%
Palm Beach	Bailey B. Sory, Jr., M.D., Brazilian Court Hotel Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	51	93%
Pasco-Hernando-Citrus	W. Wardlaw Jones, M.D., Dade City	G. R. Creekmore, M.D., Brooksville	2nd Thursday 7:00 P.M	Varies	12	92%
Pinellas	N. M. Marr, M.D 812 Power & Light Bldg., St. Petersburg	W. C. McConnell, M. D. 1005 Equitable Bldg. St. Petersburg	1st and 3rd Friday 6:30 P.M.	Sbrine Club St. Petersburg	85	98%
Polk	R. E. Gilbert, M.D., 19 Postal Arcade, Winter Haven	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	54	90%
Putnam	H. A. Johnson, M. D. Palatka	F. Emory Bell, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Johns	Charles C. Grace, M.D., East Coast Hospital St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	11	100%
St. Lucie-Okeechobee-Indian River-Martin	H. D. Clark, M.D., Ft. Pierce	Grover C. Hardie, M.D., Ft. Pierce	3rd Thursday 8:00 P.M.	Varies	14	100%
Sarasota	O. H. Cribbins, M. D. 224 Commercial Court Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	14	82%
Seminole	H. D. Smith, M.D., Touchton Drug Bldg. Sanford	Douglas G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	13	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E Mitchell, M.D., Bushnell	2nd Tuesday	Varies	4	100%
Taylor	G. H. Warren, M.D., Perry	J. C. Ellis, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	8	100%
Volusia	J. Ralston Wells, M.D., Woolworth Bldg. Daytona Beach	R. L. Miller, M.D., 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M	Varies	35	88%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood	R. B. Spires, M D., Defuniak Springs	3rd Thursday 8:00 P.M.	Varies	5	100%
Washington-Holmes	George W. Carter, M. D., Caryville	Francis M. Watson, M. D., Chipley			6	86%

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